Exhibit A

UNITED STATES DISTRICT COURT.
DISTRICT OF NEW JERSEY

IN RE: VALSARTAN, LOSARTAN, AND IRBESARTAN PRODUCTS LIABILITY LITIGATION — MDL NO. 2875
HON. ROBERT B. KUGLER

THIS DOCUMENT RELATES TO:
In Re: Valsartan, Losartan and Irbesartan Products Liability Litigation,
Case No. 1:19-md-2875-RBK

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HIGHLY CONFIDENTIAL REMOTE VIDEOTAPED DEPOSITION
OF TIFFANIE MRAKOVICH
THURSDAY, JULY 22, 2021
9:08 a.m.

Witness' Location:
1200 East Market Street
Akron, Ohio

TRANSCRIPT of the stenographic notes of the proceedings in the above-entitled matter as taken by and before DAVID LEVY, a Certified Court Reporter and Notary Public of the State of New Jersey, held remotely over the Internet, on Thursday, July 22, 2021, commencing approximately 9:08 in the forenoon, pursuant to Notice.

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(All appearances are remote via Zoom conference.)

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NICHOLAS LAYMAN, Videographer

----------INDEX----------

WITNESS	EXAMINATION	PAGE
TIFFANIE MRAKOVICH	MR. OSTFELD	7

MRAKOVICH EXHIBITS		FOR IDENT.
Exhibit 1	Membership chart and backup, 14 pages	21
Exhibit 2	E-Mail chain Bates numbered MSP-SUMMACARE-003553 through 002556	50
Exhibit 3	Formulary excerpts, not consecutively Bates numbered	58
Exhibit 4	2015 formulary co-pay schedule effective 1/1/15, three pages	86
Exhibit 5	Updated formulary co-pay schedule, effective 8/1/15, three pages	92
Exhibit 6	Formulary changes Excel spreadsheet 2015-2016 MSP-SUMMACARE-006239.XLSX	96

----------INDEX----------

MRAKOVICH EXHIBITS (Cont'd.)		FOR IDENT.
Exhibit 7	Side-By-Side July October November 2018 formularies, three pages	105
Exhibit 8	PBM Agreement with MedImpact, 225 pages, Bates numbered MSP-SUMMACARE-005978 through 006202	135
Exhibit 9	E-Mail chain Bates numbered MSP-SUMMACARE-2670 through 2672	153
Exhibit 10	MedImpact recall letter 7/18/18, Bates numbered MSP-SUMMACARE-002358 and 2359	156
Exhibit 11	MedImpact member letter dated 7/18/18, with cover e-mail, Bates numbered MSP-SUMMACARE-003035 through 3041	163

----------INDEX----------

MRAKOVICH EXHIBITS (Cont'd.)		FOR IDENT.
Exhibit 12	MedImpact Camber recall letter with cover e-mail chain, Bates numbered MSP-SUMMACARE-002836 through 2839	168
Exhibit 13	MedImpact Torrent recall letter with cover e-mail chain, Bates numbered MSP-SUMMACARE-2823 through 2826	171
Exhibit 15	E-Mail chain dated 7/23/28, Bates numbered MSP-SUMMACARE-3032 through 3034	175

VIDEOGRAPHER: Good morning. We're going on the record at 9:08 a.m. on July 22nd, 2021. This is media unit 1 of the video recorded deposition of Tiffanie Mrackovich taken by counsel in the matter of In re: Valsartan, Losartan et al. filed in the United States District Court, District of New Jersey, case MDL number 2875. My name is Nicholas Layman from the firm Veritext, and I'm the videographer. The court reporter is David Levy from the firm Veritext.

I'm not authorized to administer an oath, I'm not related to any party in this action, nor am I financially interested in the outcome. Counsel will be noted on the stenographic record.

Will the court reporter please swear in the witness and then we may proceed.

T I F F A N I E M R A K O V I C H , having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY

MR. OSTFELD:

Q. All right, good morning, Ms. Mrakovich. Am I pronouncing your last name correctly?

A. Yes.

Q. I just introduced myself to you a moment

ago but, for the record, my name is Greg Ostfeld. I'm one of the attorneys representing Teva Pharmaceuticals USA, Inc., in this case. Could you please state and spell your name for the record?

A. Sure. Tiffanie Mrakovich, T-i-f-f-a-n-i-e, M-r-a-k-o-vi-c-h.

Q. Thank you. And have you ever been known by any other name?

A. Yes. My maiden name is Tiffanie Swartz, S-w-a-r-t-z.

Q. And what is your business address?

A. 1200 East Market Street, Akron, Ohio.

Q. Have you ever been deposed before?

A. No.

Q. All right. So you probably had an opportunity to speak with your counsel about this. But just to make sure that you and I are on the same page, I'd like to go over a couple of the ground rules that will make this process a little easier today, especially given we're doing this remotely, which is already a complicated and awkward process and made more so when you've got a bunch of attorneys on the line and a court reporter and a videographer.

So I'll start with the simple stuff. You understand that you're under oath just like if

you were testifying in a courtroom?

A. Correct.

Q. And for the benefit of the court reporter, when you and I speak with one another today, it's important that we not treat it the way we would an normal conversation where we might know where the other one is going and just kind of jump in and start talking or interrupt a little bit, not out of rudeness but just to kind of move thing along.

We have a court reporter who is taking down everything I say and ever you say, and everything anybody else says, and his life will be made much easier if each of us just pauses for a moment to make sure the other has finished speaking, before we begin speaking, is that fair enough?

A. Yes.

Q. Likewise, the court reporter can't really take down, like, shakes of the head or nods of the head or body language. There's a way of indicating that but it's not as meaningful as words that are spoken out loud. So if at some point I say, "Is that a yes," "Is that a no," I'm not doing that to be pedantic, I'm doing that for the benefit of the court reporter and for the benefit of the record, okay?

A. Sure.

Q. If at any time I ask a question that you do not understand, which will certainly happen at times during the day today, that's not a problem, just let me know and I will do my best to rephrase my question in a way that you understand it; okay?

A. Okay.

Q. If you do answer my question, I'm going to assume that you understood it; is that fair enough?

A. Yes.

Q. If at any point you want to take a break, that's fine. We'll take as many breaks as you want. We're going to be spending some time together today. This isn't meant to be a marathon or an endurance contest. This is supposed to be as comfortable as we can make it for you.

My only request will be, if there's a question pending, unless you feel like you must speak with your attorney, I would ask that you answer the question before you take your break; fair enough?

A. Okay.

Q. The last thing that I will say is that because we're in a remote environment, we don't get the benefit of being in a room together and getting

to see each other, and that involves a lot of trust on each of our parts.

So you know, just as if you were testifying in court, if you were looking at a written piece of paper or looking at notes or consulting something to answer my questions, I would be entitled to see what you were doing or to know that you were doing that. So if you consult something other than your memory in answering my questions today, I would ask that you let me know that you're doing that, and let me know what you're consulting or what you're looking at, okay?

A. Okay.

Q. Have you brought any notes or devices or anything with you today that you were planning to consult during the deposition today?

A. I do have my laptop with some notes that I had jotted down at a point.

Q. Okay. And I'm not suggesting that you're not allowed to consult that. You're certainly welcome to if it will help you testify today. If you do so, I will just ask that you let me know and I may ask to see the notes that you're consulting, okay?

A. Okay.

Q. Great. Then the only other thing that I

would ask is that, I know that you're there with the Assistant General Counsel -- is it Assistant General Counsel or Associate General Counsel? You're there with an attorney from your company. Is there anyone else in the room with you?

A. No.

Q. Okay. My last request would be, if somebody else enters the room, you know, other than just for like incidental purposes, just, you know, if someone is passing through or whatever, that's fine. But if somebody else enters the room and is planning to stay, will you please let me know?

A. Yes.

Q. Okay. Any questions on your part before we go into this today?

A. No.

Q. Do you understand that you are testifying today as a corporate representative?

A. Yes.

Q. Could you please explain to you your understanding of what it means to be testifying as a corporate representative?

A. I am testifying that the drugs that are in question today were not -- should not be covered by our organization because they contain products we

do not believe we should cover.

Q. And when you say "our organization," you're referring to SummaCare?

A. SummaCare.

Q. And you understand that you're testifying today not just as to your personal or individual knowledge but as a representative of SummaCare on the claims that it assigns to the plaintiff in this case, MSP Recovery Claims Series?

A. Yes.

Q. And have you had an opportunity to review the list of topics on which you've been designated as a representative?

A. Yes.

Q. Do you believe that you understand and are prepared to testify on each of those approximately 23 topics?

A. There are some I am not a hundred percent clear on but the bulk of them, yes.

Q. Okay. And you know, I don't expect you to be able to recite the topics from memory but if you could describe for me in general terms what the topics are that you're less clear on, please.

A. Topics related to warranties are ones that are not as clear on what the ask is, or what

information you're seeking.

Q. Okay. Well, why don't we start there. When you say that you're confused by that topic, is it your understanding that the manufacturers, distributors or retailers of Valsartan made any warranties to SummaCare as a third-party payor?

MR. WHORTON: Objection to form.

THE WITNESS: I'm sorry?

MR. WHORTON: I'm sorry, I just made an objection to form. You can still answer.

A. They -- SummaCare does not have any direct relationships with manufacturers who -- we do not have any warranties in place with manufacturers directly.

Q. Okay. Do you have any warranties in place directly with wholesalers?

A. No.

Q. Do you have any warranties in place directly with pharmacies or retailers?

A. No.

Q. All right. Other than the warranty topics, are there any other topics on which you feel you don't have a complete understanding or feel unprepared to testify?

A. Not at this time.

Q. All right. So for this next question, I'm not asking you to describe the substance of any conversations with your attorney. Those are privileged and I don't want to know those, so don't disclose any of that. But my next question is, what have you done to prepare for your deposition today?

A. I reviewed the case, the notice, went through our processes, knowledge and refreshed on the PBM agreement, reviewed the formularies and our benefits.

Q. Okay. I'm sorry, I'm having a little bit of the same problem the court reporter is having, your voice sounds a little bit soft to me. Is it possible to move the phone a little bit closer to you?

A. Sure. Is that better?

Q. I think so. We'll see how that works. All right. How much time did you spend preparing for your deposition?

A. Three hours.

Q. Okay. Without getting into any of the contents of conversations with attorneys, whom did you speak with in preparing for your deposition today?

A. The conversation with Charlie from MSP,

that was an hour-long conversation.

Q. Did you speak with anyone else in preparing for your deposition?

THE WITNESS: Charlie, I know someone else was with you. I don't recall the name.

MR. WHORTON: I think David.

Greg, if you just -- I'm not trying to testify, but I want to make the record complete.

MR. OSTFELD: Okay.

Q. I heard Mr. Whorton say that he and Mr. DaPont from his firm were there. And then, Ms. Mrakovich, I think you were going to identify someone else that was at the meeting?

A. Mike Frye was also at the meeting.

Q. Okay. And that was all one meeting with you and the three of them?

A. Yes.

Q. Okay. Did you speak with anyone else in preparing for your deposition today?

A. No.

Q. Did you review any documents in preparing for your deposition today?

A. Yes, recall notice, the notice of the -- whatever this is that we're going through -- and my formularies, plan information, policies.

Q. Okay. Are you currently employed by SummaCare?
A. Yes.
Q. How long have you been with SummaCare?
A. Five-and-a-half years.
Q. And what is your title?
A. Director of Pharmacy.
Q. How long have you been the Director of Pharmacy?
A. For probably four years.
Q. And what are your primary responsibilities as the Director of Pharmacy?
A. Everything as it relates to pharmacy, so managing the relationships with our PBMs, ensuring that they are administering our benefits as we have them outlined; we have several lines of business, of which managed Medicare is primary, that takes a lot of oversight of the PBMs. I'm responsible for the Pharmacy and Therapeutic Committee, and the formularies that we offer, responsible for medical drug benefit information. It's a whole host of things that I do.
Q. Okay. Did you hold a title at SummaCare prior to the Director of Pharmacy?
A. Yes.

Q. What was your previous title?
A. Manager of Formulary and Pharmacy Benefits.
Q. All right. And how long did you hold that position?
A. For a year-and-a-half.
Q. All right. Have you held any other titles at SummaCare?
A. No.
Q. Who was your previous employer before SummaCare?
A. PDMI.
Q. All right. And how long were you there?
A. Five years.
Q. All right. Was that PD or TD?
A. P as in Paul, D as in dog, MI.
Q. Okay. And what was your title there?
A. Medical pharmacist.
Q. Could you briefly walk us through your educational background?
A. Sure. I got my undergrad at the University of Findlay in biology and environmental health and science, and did work in that field for five years or so; and then went back to pharmacy school at NEOMed in Ohio and got my pharmacist degree

ten years ago.

Q. And was PDMI your first employer after pharmacy school?

A. Yes.

Q. Are you employed by SummaCare or by Summa Health Systems?

A. SummaCare.

Q. Okay. And are you familiar with what the relationship is between those two entities?

A. I'm not intimately aware, but I understand that that is our -- Summa Health is our parent company.

Q. Okay, got it. All right. And you are currently in Akron, Ohio. Is SummaCare based in Ohio?

A. Yes.

Q. Are you joining this deposition from SummaCare's offices today?

A. Yes.

Q. Are all of SummaCare's operations in Ohio?

A. Yes.

Q. Are all of SummaCare's members or beneficiaries in Ohio?

MR. WHORTON: Objection, vague.

Q. You can go ahead and answer if you are able to.

A. The base of all of them are in Ohio but I know we have a few members that are outside of our area.

Q. Okay. What is SummaCare's area?

MR. WHORTON: Objection, vague.

Q. You can go ahead.

A. As it relates to a particular line of business?

Q. Well, you just used the phrase, "Outside of our area." So I'd like to understand what you mean by SummaCare's area.

A. It is primarily Ohio.

Q. Okay. And when you use the phrase, "Our area," that's the area where SummaCare's membership is based?

A. Yes.

Q. Okay. Just because it's happened a few times now and I'm sure it will happen a lot more during the day, I didn't cover what happens when an objection is made.

So for the most part, at times during the deposition, Mr. Wharton is going to make an objection, like he'll say, "Objection, vague,"

"Objection, form," and he's typically doing that for the record. So after he's made an objection, you can go ahead and answer the question unless you feel like you need clarifying or you're not able to answer it, okay?

A. Okay.

Q. And if you're not supposed to answer, I'm quite confident one of your attorneys will tell you not to answer. Otherwise you can just go ahead and do so. It's being made for the record so if a judge has to rule on this later, the judge can do so, fair enough?

A. Sure.

Q. All right. So I think what I'd like to do next is learn a little bit more about SummaCare's membership and plans. So I am going to try to share screen.

(A pause in the proceedings.)

Q. All right. Hopefully, you now have a shared screen in front of you with a document that is marked Exhibit 1. Do you see that?

A. Yes.

EXH (Mrakovich Exhibit 1, membership chart and backup, 14 pages, marked for identification, as of this date.)

Q. All right. So the first page of this is not going to be familiar to you. I will represent to you that the first page of this exhibit is a chart that we prepared from SummaCare's annual financial overviews and then there's a bunch of other pages that are the annual reports that we used to build this chart.

I'm not going to ask you, unless you want to, to read all of those reports in detail right now. But I just want to scroll through them really fast and ask you in general if you're familiar with these documents.

MR. WHORTON: Greg, I'm sorry, are you going to put this in the chat room so others can download it and look at it?

MR. OSTFELD: It's in the Exhibit Share, the Veritext Exhibit Share room.

MR. WHORTON: Okay. All right, thank you.

MR. OSTFELD: Sure.

Q. Are these reports that you're familiar with?

A. I have not reviewed these reports.

Q. Okay. You're not involved in preparing these reports?

A. No.

Q. All right. The type of information contained in this report, SummaCare total members and just, for the record, I'm currently showing you the financial group for 2016 year-end review, and there's a series of SummaCare total members broken down by category and then a total number of 120,396.

Is the membership base of SummaCare's plans something you're familiar with?

A. Yes.

Q. All right. So the first page of this, what we've done for convenience is summarize those individualized breakdowns of membership numbers for each year from 2013 to 2019; do you see that?

A. Yes.

Q. And I will represent to you that we have transcribed the numbers -- you just saw the sample numbers for, I think it was 2015 or 2016 -- we took those numbers from each report and transcribed them into this chart.

So I will represent to you that we've done that, okay?

A. Okay.

Q. So understanding that you almost certainly don't have the exact numbers in your memory

and at your fingertips, do these numbers generally look right to you as the breakdown of SummaCare's membership from 2013 to 2019?

A. Yes.

Q. Okay. It looks like the number of members has declined year to year each year from 2013 to 2019. Is that right?

A. Yes.

Q. Do you have an understanding of why the numbers have declined each year?

A. In some areas, yes.

Q. Okay. Could you please share with me your understanding in the areas where you have one?

A. Um -- sure. For Medicare, I know, we've had -- well, in 2014, we did have a sanction with CMS and that put our membership for standing members in 2015 on hold, so -- and that's probably disrupted some of our membership. So that was the major decline in the Medicare line of business.

And then just -- we have not had strong sales to gain the membership back. It's been a pretty stagnant enrollment around here.

Q. Okay. Now, the reports broke down SummaCare's membership into as many as five categories. So one of the categories kind of went

away in 2018 and 2019. The five categories are commercial self-insured, commercial fully-insured, group BPO/PS and Medicare and individual PPO. Are you familiar with each of those categories and what each category represents?

A. Not in detail. Just vaguely.

Q. Okay. Then I guess what I'd like to do is get your best understanding of each of the categories and we'll go through them. What is your understanding of what commercial self-insured is?

A. Well, there are self-funded benefits wherein the insurer is taking on all the risk and we're administering the benefit on their behalf.

Q. Okay. And just to kind of go bigger-picture for a moment, does each of these categories represent a different category of plans that are offered by SummaCare?

A. Yes.

MR. WHORTON: Objection.

Q. Okay. So when we're talking about commercial self-insured, we're talking about commercial self-insured plans where the sponsor of the plan is taking on all of the risk?

A. Yes.

Q. Okay. What is commercial fully-insured?

A. That is where SummaCare is taking some of the risk and we are building the benefits and offering them to groups and they can elect to buy or not, in the fully-insured.

Q. I want to understand a little bit better what you mean when you say, when you talk about who is taking on the risk.

Are you speaking in terms of who is paying the benefit?

A. I guess I don't know.

Q. Okay. So for example, when we're talking about a commercial self-insured plan, if a member fills a prescription under a commercial self-insured plan, who is paying the cost for that prescription, or who is paying the plan's share of the cost of that prescription?

MR. WHORTON: Objection. If the witness could -- I'm sorry, sometimes I'll lodge an objection. So if you could just have a brief pause after the question so I can lodge an objection if necessary. I was objecting based on the question lacking foundation.

MR. OSTFELD: Why don't I go ahead and restate the question.

Q. So Ms. Mrakovich, when we're talking

about a commercial self-insured plan, do you have an understanding of who pays the plan's share of the cost when a member fills a prescription under a commercial self-insured plan?

A. Yes.

Q. Okay. Who incurs that cost?

A. We invoice the client self-insured group for the drug cost.

Q. Okay. So ultimately, it's the client who pays that cost.

A. Ultimately, yes.

Q. All right. And not SummaCare.

A. Correct.

Q. So to the extent that you're involved in the payment, it's as a pass-through transaction.

A. Yes.

Q. How about for a commercial fully-insured plan?

A. I have an understanding but I don't know --

Q. But you don't know? I'm sorry?

A. I don't know if my understanding is a hundred percent correct.

Q. Okay. I'll take that caveat, and why don't you just share what your understanding is.

MR. WHORTON: Objection, calls for speculation.

Q. Go ahead.

A. That SummaCare will pay for those funds by premiums from these fully insured groups to cover the cost.

Q. Okay. So in that instance, SummaCare is collecting premiums from the client and the costs are covered by SummaCare out of the premiums, is that right?

A. That's my understanding.

Q. Okay. And to the extent that the costs exceed the premiums, that's the risk that SummaCare is incurring?

A. Could you restate that?

Q. Sure. If it turns out that the total cost incurred by the plan in that year exceeds the total premiums collected, that's the risk that you're referring to that SummaCare is taking on?

A. Correct.

Q. Okay. So I want to understand just a little bit better the flow of payments that you described for that pass-through transaction for a self-insured plan.

And for that I think I'm going to have

to introduce the Pharmacy Benefits Manager concept. So the SummaCare uses Pharmacy Benefits Managers, is that right?

A. Yes.

Q. Do the Pharmacy Benefits Managers have any role in the flow of payments for a self-insured plan?

MR. WHORTON: Objection, vague.

A. I'm not sure I understand.

Q. Okay. Maybe it would be easier if I just asked you to walk me through what happens from a plan reimbursement perspective when a member goes to the pharmacy and fills a covered prescription under a self-insured plan. Could you walk me through that process?

A. Sure. So a member goes to the pharmacy, presents their insurance card. That will get submitted to the PBM, they will process the claim based on our benefit design, and send it back to the pharmacy what the member owes. And then MedImpact, which is our PBM, will pay the pharmacy and then they will send us a batch invoice for all claims for that line of business and then we will pay MedImpact.

We'll take, for the self-funded groups, we'll take that invoice for the drugs and we will

tack that on and bill the self-funded client.

Q. Okay, thank you, that was very helpful. So that's how it works for the self-funded groups. How about for the fully-insured plans, how does that process differ for the fully-insured plans?

A. So the same -- it starts the same with the member going to the pharmacy, presenting their card, and getting billed to MedImpact. MedImpact will pay the pharmacies and then we will be billed the invoice for the drugs for the fully-insured line of business. We do not take a claim, then, and pass them on to the fully-insured client.

Q. Okay. So essentially the difference from a payment flow perspective between a self-insured and a fully-insured plan is, so for the self-insured plan, you proceed to invoice those costs to the plan sponsor. For the fully-insured plan, the payments stop with SummaCare because you've collected premiums to cover those payments, is that right?

A. That's my understanding.

Q. Okay. So let's move to the next category, "Group PBO/PSN." I'll start with, do you know what those acronyms mean?

A. I do not.

Q. I looked all the -- I found the terms

"Business Process Outsourcing" and "Professional Services Network." Do those sound right to you?

A. I really don't know that much about that line of business because it was really fading out when I started here. I didn't have any focus there.

Q. Okay. All right. Do you have any knowledge or understanding of how those plans work?

A. I do not.

Q. Okay. Do you have any knowledge of who pays members' claims under those plans?

A. I do not.

Q. Okay. I also want to make sure I'm getting my terminology right. I've been using the word "members." Is that how you all designate plan members or enrollees or beneficiaries under your plans or do you use one of those other terms?

A. Any of those work for me.

Q. And does the terminology differ if we're talking about Medicare plans vs. commercial plans vs. individual plans?

A. No.

Q. Okay. All right. So then let's move on to Medicare plans which, if I've understood your testimony earlier, you spend a lot of time dealing with the Medicare plans, is that right?

A. That's correct.
Q. Okay. So could you describe for me what the Medicare plans are.
A. In what respect?
Q. So I guess I'll start with the basics. Does Medicare refer to both Medicare Part D and Medicare Advantage plans?
MR. WHORTON: Objection to form.
Q. Go ahead.
A. From the standpoint of these numbers, I'm not sure what Summa Health reported out, if it was only those that had Part D or a combination, I'm not -- I can't speak to that from the reporting that you've pulled.
Q. Okay. Does Medicare -- I'm sorry, does SummaCare have both Medicare Part D and Medicare Advantage plans?
MR. WHORTON: Objection to form.
A. I mean, I do believe all advantage plans have Part D.
Q. Okay. So do you have Medicare Part D plans that do not have a Medicare Advantage component?
A. No.
Q. Okay.

A. Not --
Q. Sorry, go ahead.
A. -- not currently.
Q. Was there a time where you did?
A. Before my time, I've heard that we had a PVP, which was only a Part D plan.
Q. But in the time that you've been with SummaCare, it's only been Medicare Advantage plans with Medicare Part D coverage?
A. And we have a very small group of Part-B-only plans, we call them, which is medical plan without a Part D benefit. We just started those in the more recent years.
Q. Okay. I want to make sure I have the time frames correct. With respect to Part D plans that were not Medicare Advantage plans, do you know if any of those existed at any time between 2013 and 2019?
A. I do not know for sure what year we had the PVP plan.
Q. Okay. In terms of the Medicare Part-B-only plans, when did you begin offering those?
A. I'm trying to think if it was 2019 or 2020. I don't recall for sure.
Q. Okay. And then do you have any plans

that offer Medicare Part A coverage?

A. I don't know.

Q. Okay. Earlier you described how the flow of payments works when a member fills a prescription at a pharmacy under the two commercial categories. Could you please describe now how that process works when a member in a Medicare plan fills a prescription at a pharmacy.

A. Yes. It would follow the fully-insured where the member presents their insurance information to the pharmacy, the pharmacy submits the claim to MedImpact, they send back to the pharmacy what the member owes, and then MedImpact will pay the pharmacy through their invoicing and then they will invoice us to collect -- invoice SummaCare to collect back some money.

Q. Okay. Now, with the commercial plans, SummaCare's premiums are coming from the plan sponsor. How does that differ for the Medicare plans?

A. We have -- our Medicare plans have premiums, so we do have one that is a zero-dollar premium, and then those are paid by the members.

Q. Okay. And is there a component of the funding for the Medicare plans that comes from CMS or

from the government?

A. Yes. That's correct.

Q. Okay. Do you know what the approximate breakdown is in terms of what the government's share of the Medicare plans are vs. what the premiums cover for the Medicare plans?

MR. WHORTON: Objection.

A. I do not.

Q. I'm sorry, you don't know?

A. I don't know.

Q. Does it differ from plan to plan?

MR. WHORTON: Lacks foundation.

A. I'm not a hundred percent sure.

Q. Okay. Whatever share of the Medicare plan comes from the government, it's paid essentially similar to the premiums, it's paid as an up-front cost and not on an individual transaction reimbursement basis, is that right?

MR. WHORTON: Objection, lacks foundation.

A. You would have to repeat the question.

Q. Sure. Well, when you were describing how a self-insured plan works, you described how SummaCare sends an invoice to the plan sponsor to cover the specific costs that SummaCare is paid to

the Pharmacy Benefit Manager. Is there a process like that for the Medicare plans where direct costs are billed to Medicare, or is it more like the premium model where the money comes in from the government like the premiums do, and then SummaCare pays the costs?

A. I know we get, based on the bid that is submitted to CMS, we get a monthly amount that's based on many factors that we use to help pay for Medicare. But it's not --

Q. Are you involved -- I'm sorry.

A. -- it is not invoiced directly based on claims.

Q. Okay. Are you involved in the bid process or preparing the bids to Medicare for the plans?

A. Yes.

Q. Could you please describe for me, just kind of at a general level, how the bid process works that leads to these monthly payments?

A. I participate on the bid process as it relates to Part D drugs formulary and information with the PBM. I don't get into the detail of the financials.

Q. Okay, got it. All right. Do you know

whether each Medicare plan is bid separately to CMS or if you bid batches of plans together?

A. Separate.

Q. Separate. Okay. Are the monthly payments under each plan separate and vary by plan?

A. I'm not sure.

Q. Okay. Let's talk about the last category, "Individual PPO." Could you describe what type of a plan the individual PPO plans are?

A. Um -- you know, I'm not a hundred percent sure. The way we break out some of our benefits and terminology internally is not the way I break them up with my PBM, so I'm not always on the same page with them.

Q. Okay. Do you have any idea of what the individual PPO plans are?

A. I would be guessing it's related to our marketplace line of business but they are no longer a PPO plan.

Q. All right. When you refer to marketplace, is that like the Affordable Care Act marketplace?

A. Correct.

Q. Okay. So -- all right, understood. For the marketplace plans that you're familiar with, do

those function like self-insured plans or like fully-insured plans?

A. Like fully-insured plans.

Q. Okay. So the customer pays a premium and SummaCare incurs the risk, essentially, of payments exceeding the premium.

A. Correct. We do have individual and small groups, but that works the same way.

Q. Okay. And the flow of payments works like the fully-insured commercial plan that you described earlier?

A. Correct.

Q. Does SummaCare administer its plans in Ohio?

A. Yes.

Q. Does SummaCare administer any plans that are not SummaCare plans, like do you have third-party contracts with any other providers to administer their plans for them?

A. Not at this time.

Q. Has there been a time where that was done?

A. Yes, and I -- I do believe that's the BPO piece that I'm not familiar with.

Q. Okay. We talked earlier about the fact

that there may be some members outside of SummaCare's service area. Could you please explain how someone from outside Ohio comes to enroll in an Ohio insurance plan?

A. Yes, those are essentially dependents, actually, of people that are in Ohio.

Q. All right. Do you know the number of plans that SummaCare currently offers across all categories?

A. It's a lot. I do not know the exact number.

Q. When you say "a lot," are we talking thousands, hundreds, dozens? I just want to, if we can narrow it down at all.

A. I would say hundreds.

Q. Hundreds. And does that number change from year to year?

A. Slightly.

Q. Okay. Do you know, of those hundreds, do you know approximately how many are Medicare plans?

A. Yes.

Q. How many Medicare plans does SummaCare currently offer?

A. I don't know off the top of my head.

Q. Are you able to provide a range?
A. Yes. Probably eight to ten individual plans and five or six employer group plans.
Q. Okay. Could you explain the difference between an individual plan and an employer group plan in the Medicare category?
A. So the individual plans are plans that we put together, submit a bid for and sell out to individuals that can sign up for our plans. An employer group plan would be where a group is paying the premium and selecting the benefits that they are going to offer to the member.
Q. Okay.
A. And they are the group paying for part of that. I'm not sure if they pass the premium on to the members or not.
Q. Okay. So in the employer group plan category for Medicare, these are all Medicare-eligible individuals that have plans through their employers?
A. Correct. A very small part of the -- it's a small part of the business.
Q. Okay. Got it. So there are some employers who offer their eligible employees Medicare Advantage plans alongside whatever private insurance

options they may offer?

A. I believe so.

Q. Okay. In terms of the breakdown of enrollment between the individual Medicare Advantage plans and the employer Medicare plans, can you give me the rough percentages in each, for each?

A. Let's say we have -- probably less than a thousand employer group plan members now.

Q. So the remaining 21,000 or so would be in individual Medicare Advantage plans?

A. Correct.

Q. In terms of the total number of Medicare plans, has that varied over the years from 2013 to 2019?

A. Yes.

Q. I'm not going to ask you for the exact number reach year. But could you please describe for me kind of what the general ranges have been over time from 2013 to 2019?

A. It's been fairly similar. We may add a plan here or remove a plan here. It's not a wide range of changes.

Q. Okay. All right.

MR. OSTFELD: We're about an hour in. I usually offer a break about every hour or so. We

haven't gone quite an hour yet, but I'm about to jump into formularies and I'm going to have a bunch of questions there, so if you'd like to take a break now, we can. If you want to keep going, we can keep going for a little while longer, I'll leave it up to you.

THE WITNESS: A break would be good.

MR. OSTFELD: Okay. Let's take, how about a ten-minute break, does that seem okay?

VIDEOGRAPHER: Stand by, to get us off the video. The time is 9:57 a.m. This concludes media unit 1.

(Recess taken.)

VIDEOGRAPHER: The time is 10:10 a.m. This begins media unit 2.

EXAMINATION (Cont'd.)

BY MR. OSTFELD:

Q. All right. Ms. Mrakovich, earlier, you indicated that you had reviewed formularies in preparing for your deposition today, is that correct?

A. Yes.

Q. All right. Could you please briefly describe what a formulary is.

A. A formulary is a list of drugs that the plan covers. It will notify the members what drugs

we cover, at what tier we'll cover them, so that they can understand what their copay will be, and if there are any restrictions as far as quantities, prior authorization requirements, step therapy requirements.

Q. And we'll talk a little bit more about those requirements later. I'd like to begin with, does SummaCare use a single comprehensive formulary across all of its plans or do the formularies differ on a plan-by-plan basis?

A. They can differ.

Q. All right. Does each plan have its own formulary?

A. Define "plans," please.

Q. Okay. Let's start with the Medicare plans, because we're going to be spending most of our time talking about those. You described earlier that there's about dozen or so Medicare plans that SummaCare offers. Do each of those plans have its own formulary or is it one formulary for all of them or somewhere in between?

A. For Medicare, we have one formulary for all of them.

Q. Okay. And does that formulary have a name or a terminology that you apply to it at

SummaCare?

A. The SummaCare Medicare formulary.

Q. Okay. I've seen documents containing the title, "Comprehensive Formulary." Is that the Medicare formulary?

A. Yes.

Q. All right. So that's on the Medicare side. How about for the commercial plans, do they have their own comprehensive formulary or their own commercial formulary?

A. We have two formularies for commercial. One is specific to our marketplace plan, and then we have another one that covers the rest of our several-funded and commercial plan.

Q. Okay. All right. Does SummaCare design its own comprehensive formulary for Medicare or are they developed by the Pharmacy Benefits Manager?

MR. WHORTON: Object to form. Vague.

A. We used to do our own custom Medicare formulary with the PBM. We did switch to a standard PBM formulary in 2015 so.

Q. So from 2015 to the present, you've been using a standard formulary prepared by the Pharmacy Benefits Manager?

A. Yes.

Q. And prior to 2015, you customized your own formularies with the PBM, is that what you said?

A. I was not here before 2015. It was a custom formulary, it was not a MedImpact standard formulary, that's all I know.

Q. Understanding that this is before your time, do you have any understanding of how the customization process worked when SummaCare customized its own formulary?

A. I do not know how that one originated. I know that they would take feedback from the PBMs when making a decision.

Q. Okay. Now that SummaCare uses a standard formulary from the PBM, is it just one option or does the PBM present multiple options and SummaCare chooses between different standard formularies?

A. There are multiple options.

Q. All right. And are you involved in selecting which formulary SummaCare uses each year?

A. Yes.

Q. All right. Could you describe how the process works for SummaCare to select a standard formulary each year?

A. We evaluate the -- PBM will put out a

white paper, a documentation that tells you what formulary options they have. The differences vary by the number of tiers you may offer and why they may choose to place some of the generic products, and then you can select how many tiers you want on your formulary, and where you want some of the generic products to fall. We evaluate against our competitors and our current utilization and decide what makes sense for us.

Q. Okay. I want to drill down a little bit on each of those two items, the number of tiers and where the generic products fall on the formulary.

How many tiers does SummaCare's current Medicare comprehensive formulary have?

A. Six.

Q. All right. And has it been six for the entire time that you've been with SummaCare?

A. No.

Q. What other numbers of tiers has SummaCare used in the past?

A. Five.

Q. Okay. Does the Pharmacy Benefits Manager offer formularies that have different numbers from either five or six tiers?

A. Yes.

Q. What are, I guess, the different tier options that have been made available, the PBM's standard formularies?

A. I don't recall them all. We've always focused on five and six.

Q. Okay. What difference does it make in terms of the number of tiers that are offered in the formulary?

A. I'm not sure I know what you're asking with that.

Q. Okay. In terms of evaluating, for example, you want five or six tiers, what are the implications of that decision from SummaCare's point of view that leads you to choose one vs. the other?

MR. WHORTON: Objection, vague.

A. The sixth tier we added several years ago, I don't remember the exact year, to cover vaccines at zero dollars per member. So that's the difference between five and six. We just moved some vaccines into the sixth tier to cover them as well.

Q. Okay, got it. So as far as the placement of generic medication, could you please describe how different formularies in terms of which tiers generic products are placed into?

A. So the SummaCare formularies I can speak

to, the SummaCare Medicare. And we've always had two tiers of generic, tier one being our preferred generics, and tier two being generic.

Q. Okay. Are there other formularies that don't put generics into multiple tiers like that?

A. I suppose you could select one, but we never have.

Q. Are there formulary options where you have more than two tiers of generic products?

A. There are formulary options where you can move generics into the higher tiering. They are not solely generic tiers.

Q. Got it. I think you said SummaCare's current Pharmacy Benefit Manager is MedImpact?

A. Correct.

Q. How long has MedImpact been SummaCare's PBM?

A. Since 2012.

Q. All right. So the entire time you've been with SummaCare, it's been MedImpact?

A. Yes.

Q. Do you know who SummaCare's PBM was prior to MedImpact?

A. Yes.

Q. Who was it?

A. Catalyst? They have changed over so many times, I think that was the name they were under at that point in time.

Q. I'm sorry, what was the name?

A. Catalyst.

Q. Catalyst. Okay. And how long was Catalyst the PBM?

A. I don't know.

Q. Okay. How often does SummaCare renegotiate or renew its contracts with MedImpact?

A. Our terms are about three years each and we do a market check somewhere in that time frame to evaluate rates.

Q. Okay. I want to understand a little bit better when you say that these are standard formularies from the PBM. Is there any customization or adjustment of the formularies or is it essentially you're shown several out-of-the-box options and you pick one of them?

MR. WHORTON: Objection to form.

A. We are shown different options, again with tiering. The drug list cannot be changed, essentially. You have some opportunities to do something in the sixth tier if you like, as we chose to put vaccines in the sixth tier for zero dollar

copay. You could elect to put Star Measure drugs in the sixth tier, or diabetic drugs in the sixth tier. So there are a few a la carte type changes you can make but you cannot specifically change certain drugs on the list.

Q. Got it. All right, I'm going to share my screen. And I am going to show you what has been marked for identification as Exhibit 2.

EXH (Mrakovich Exhibit 2, e-mail chain Bates numbered MSP-SUMMACARE-003553 through 002556, marked for identification, as of this date.)

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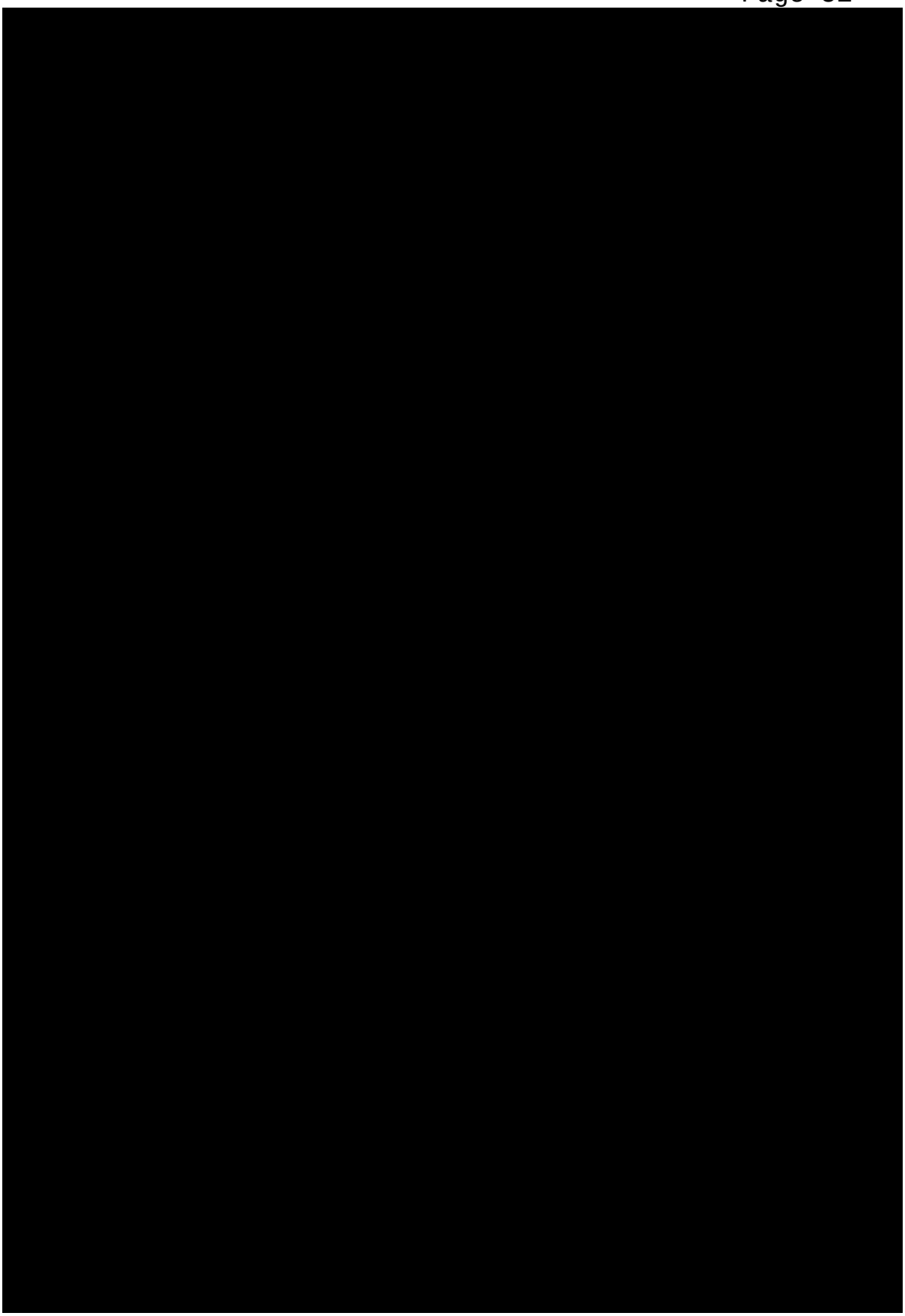

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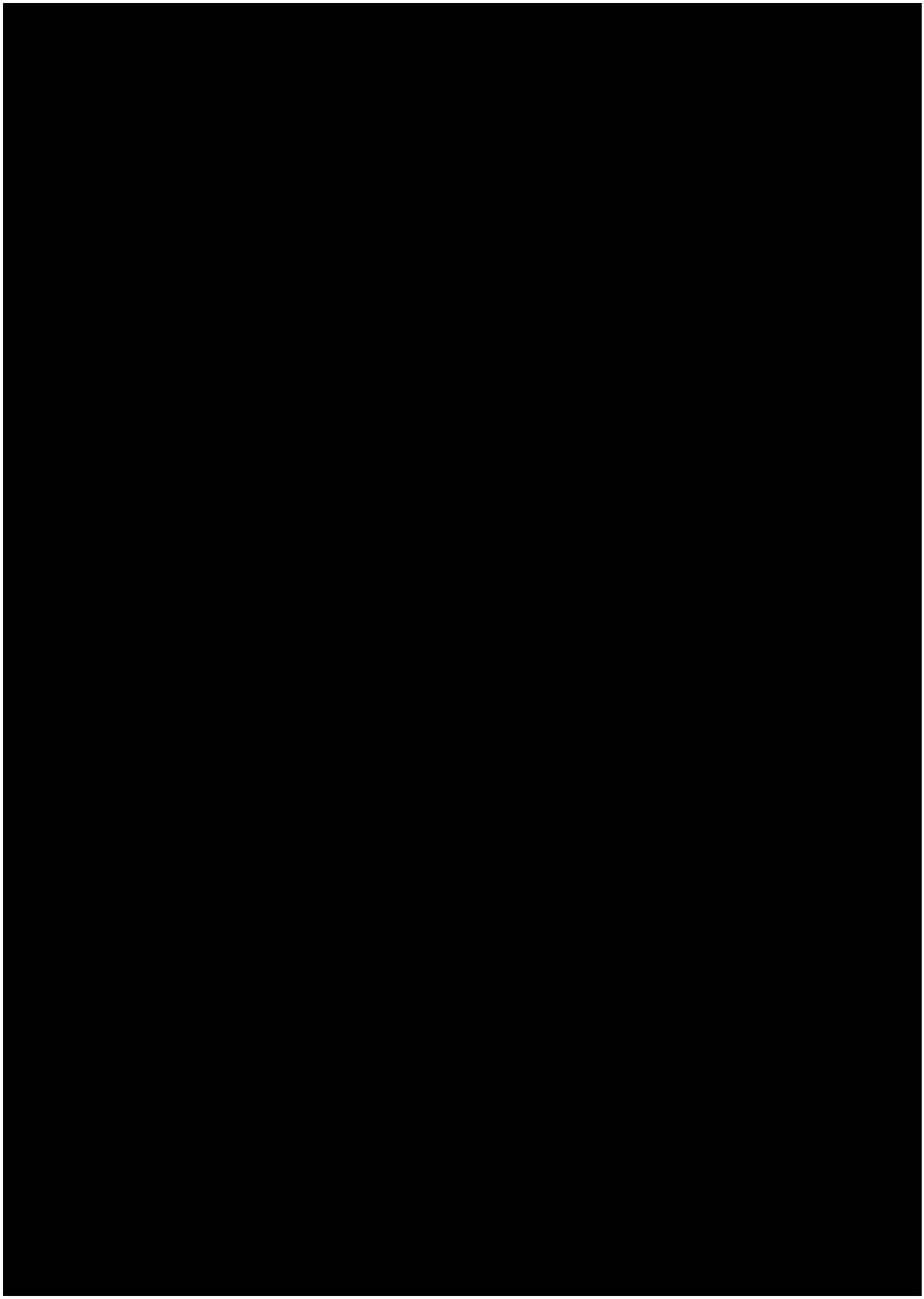

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Q. I'm going to stop sharing for a moment so I can switch exhibits.

MR. WHORTON: Greg, was that Exhibit 2?

MR. OSTFELD: That was Exhibit 2. And incidentally, I have a bad history of sometimes forgetting to share my screen; so if at some point I'm asking you questions and it appears like I'm referring to a document and you have no idea why there's nothing on screen, if you could just let me

know, I probably just need a reminder to share my screen.

All right, I am now showing you what has

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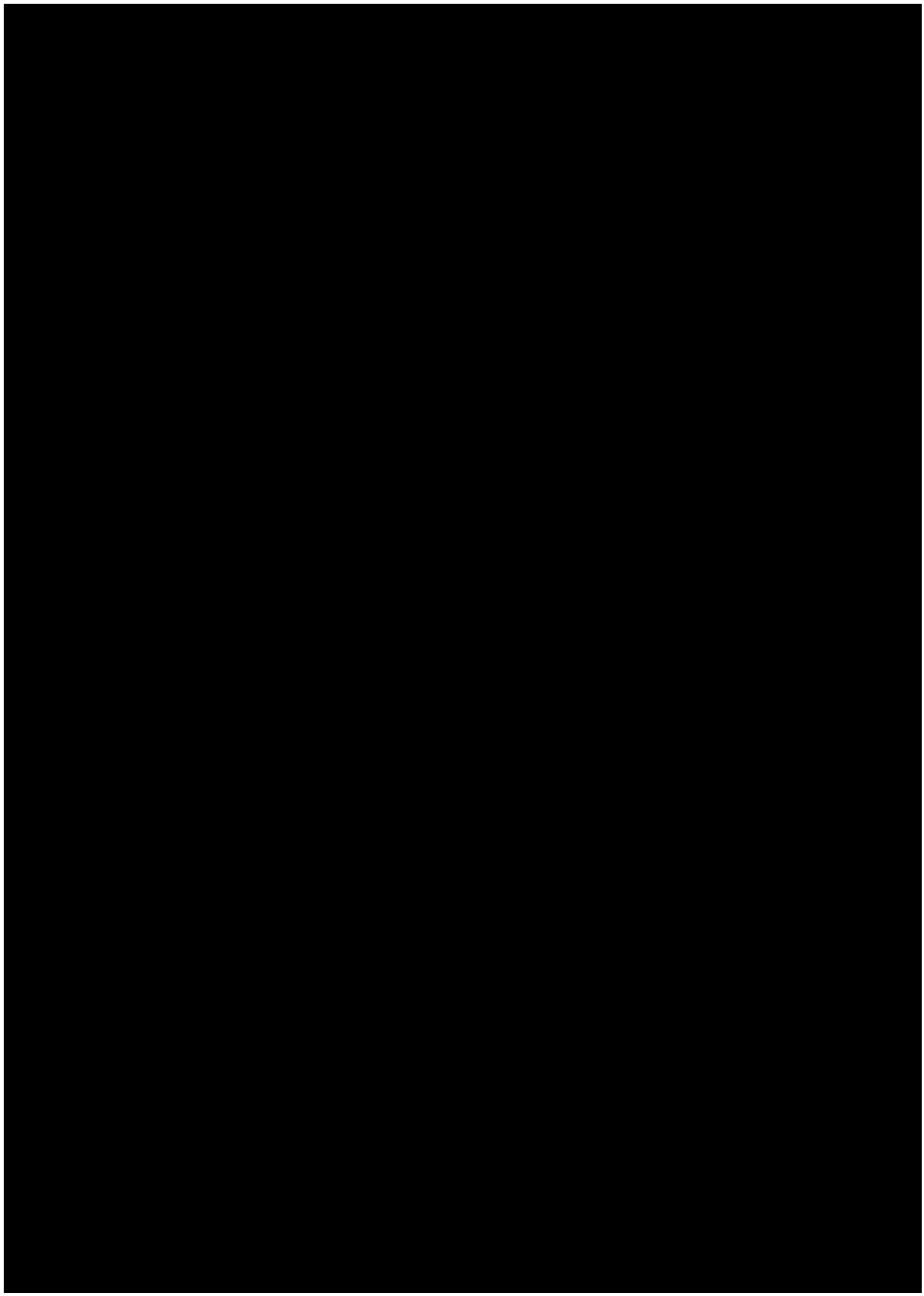

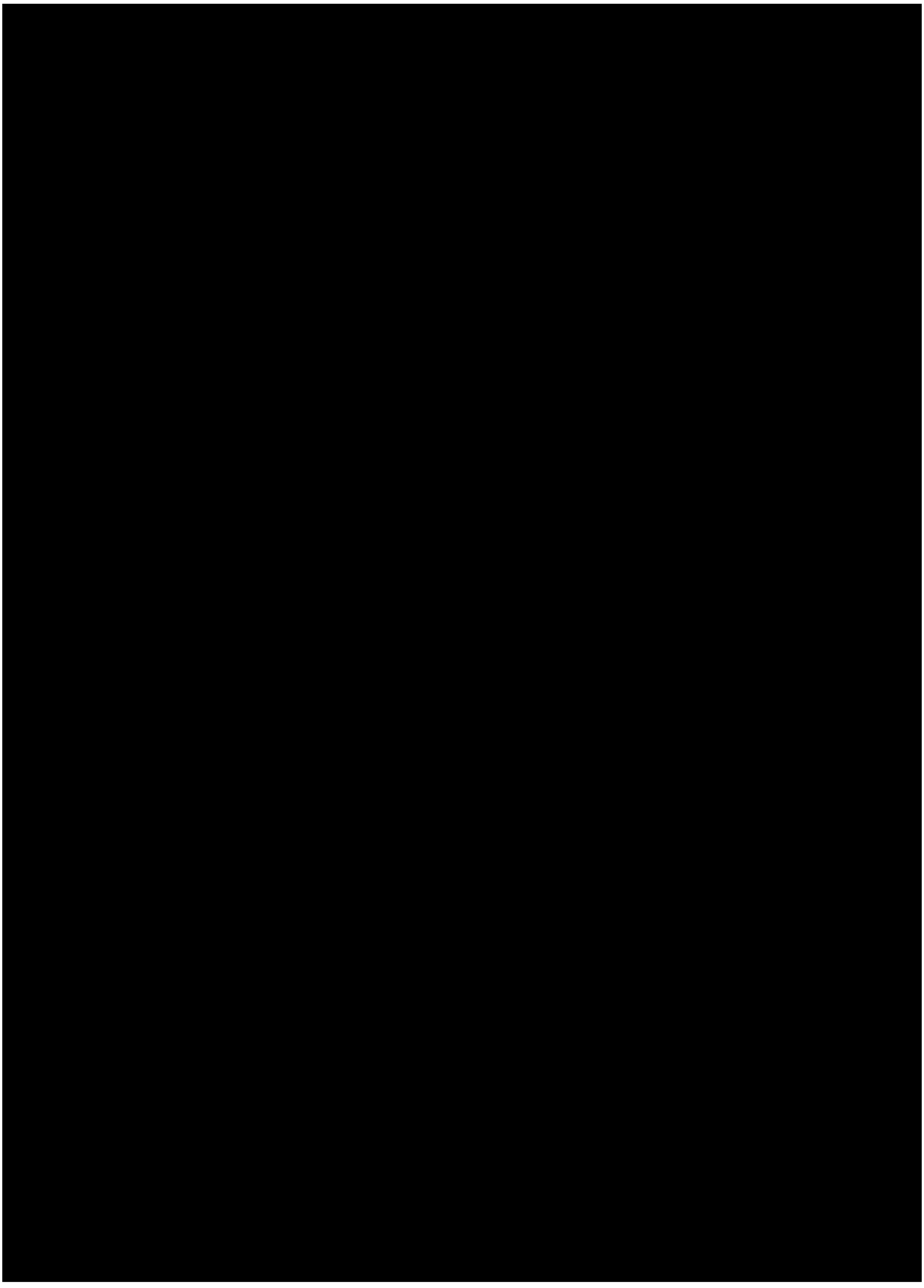

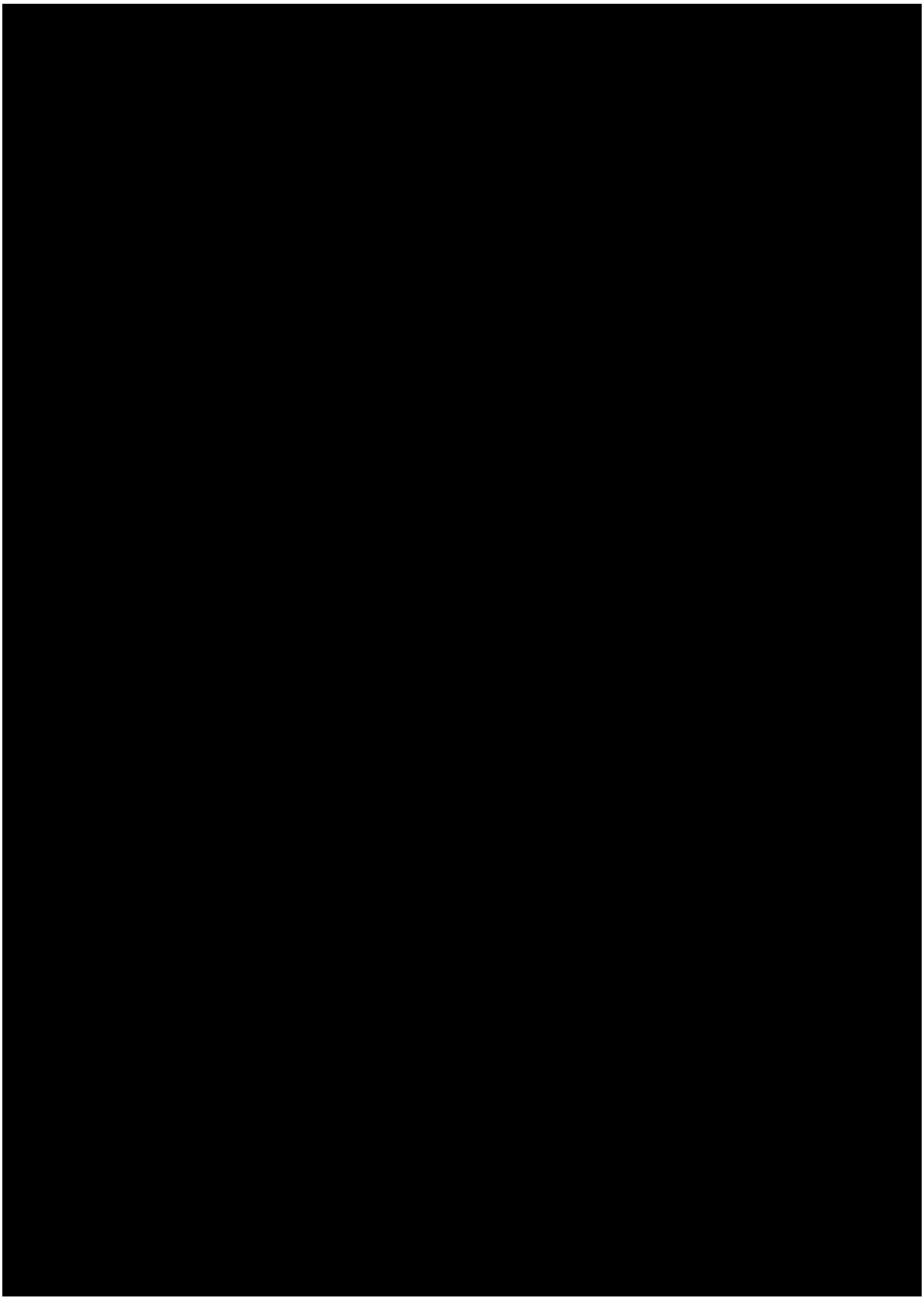

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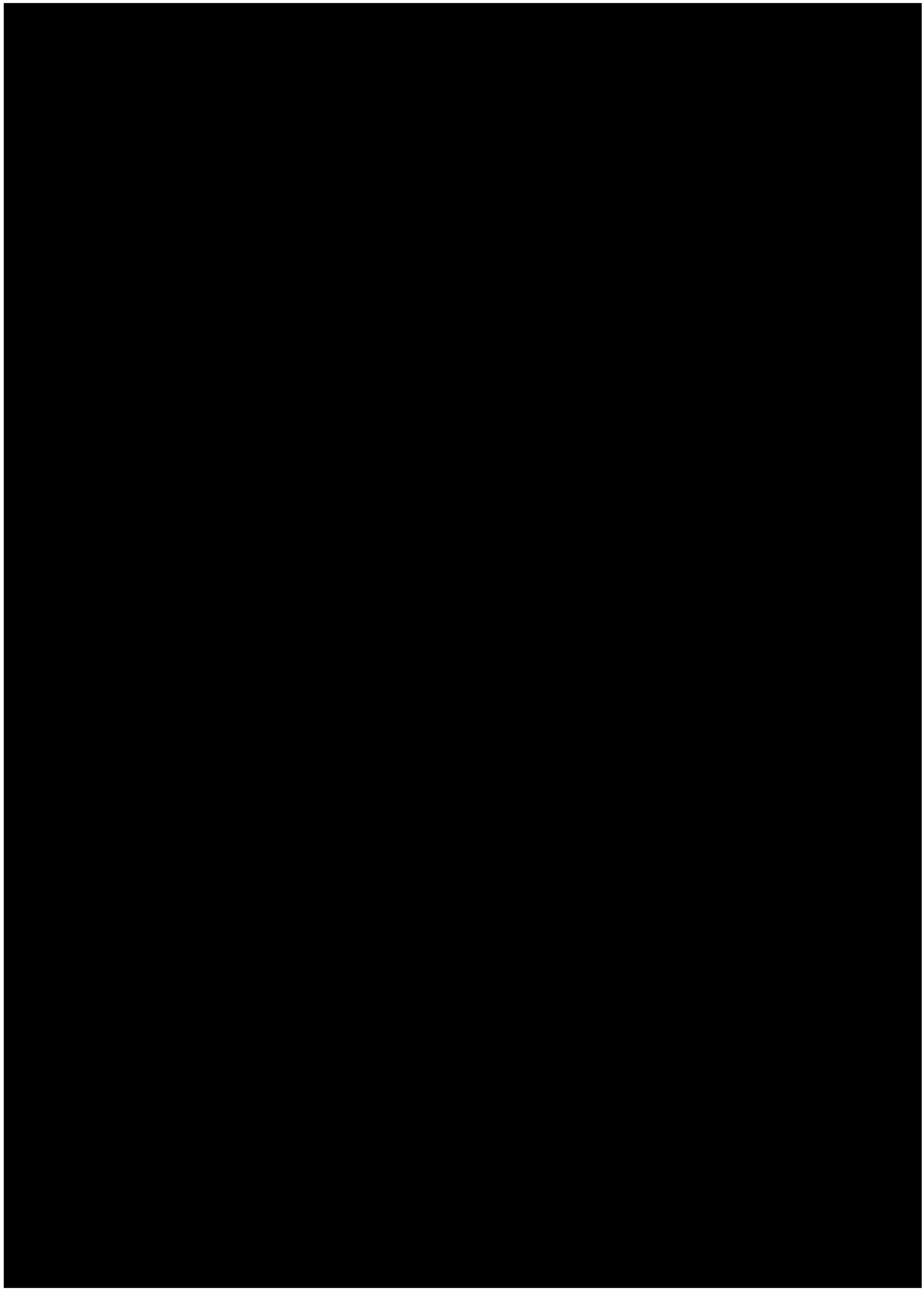

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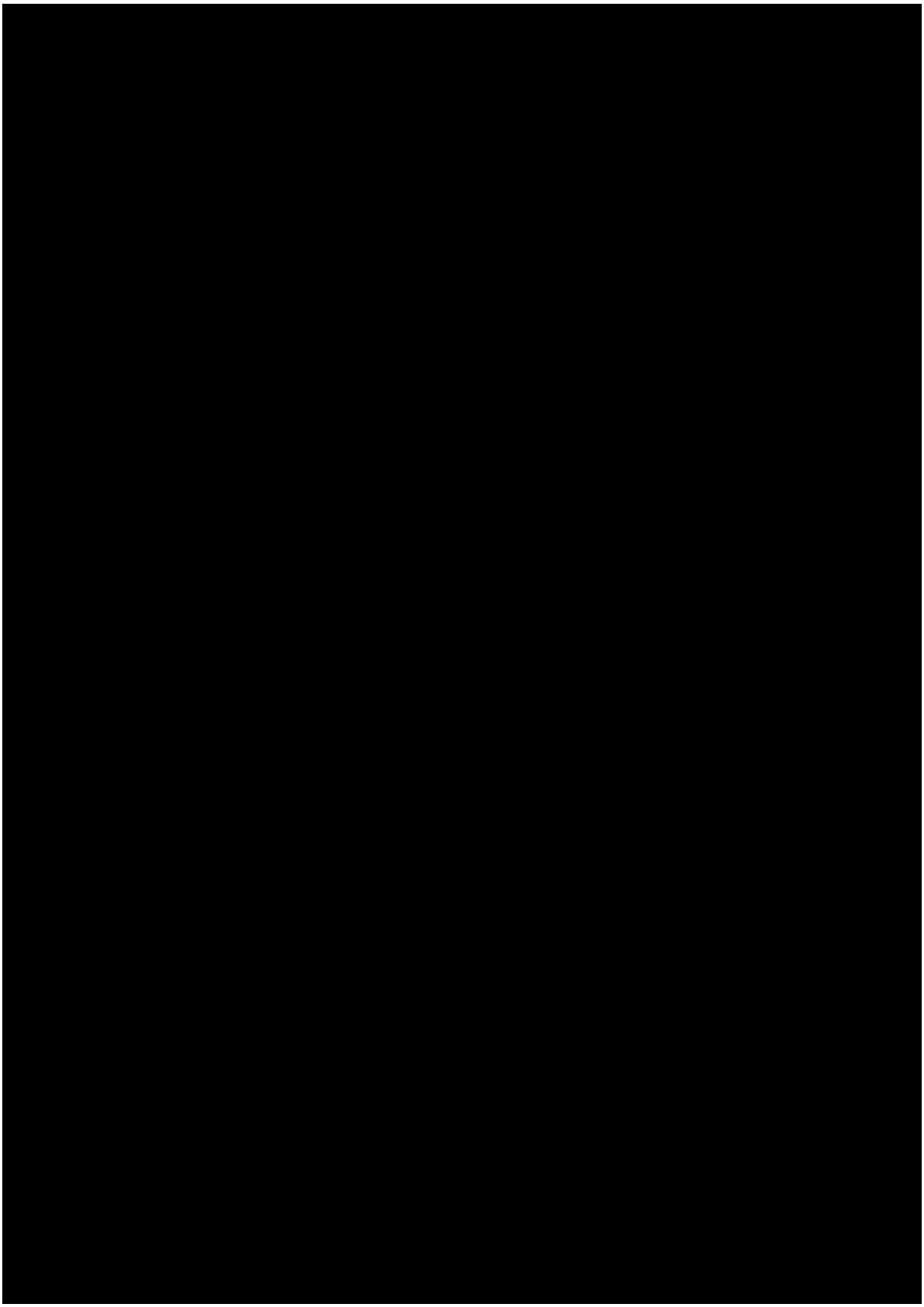

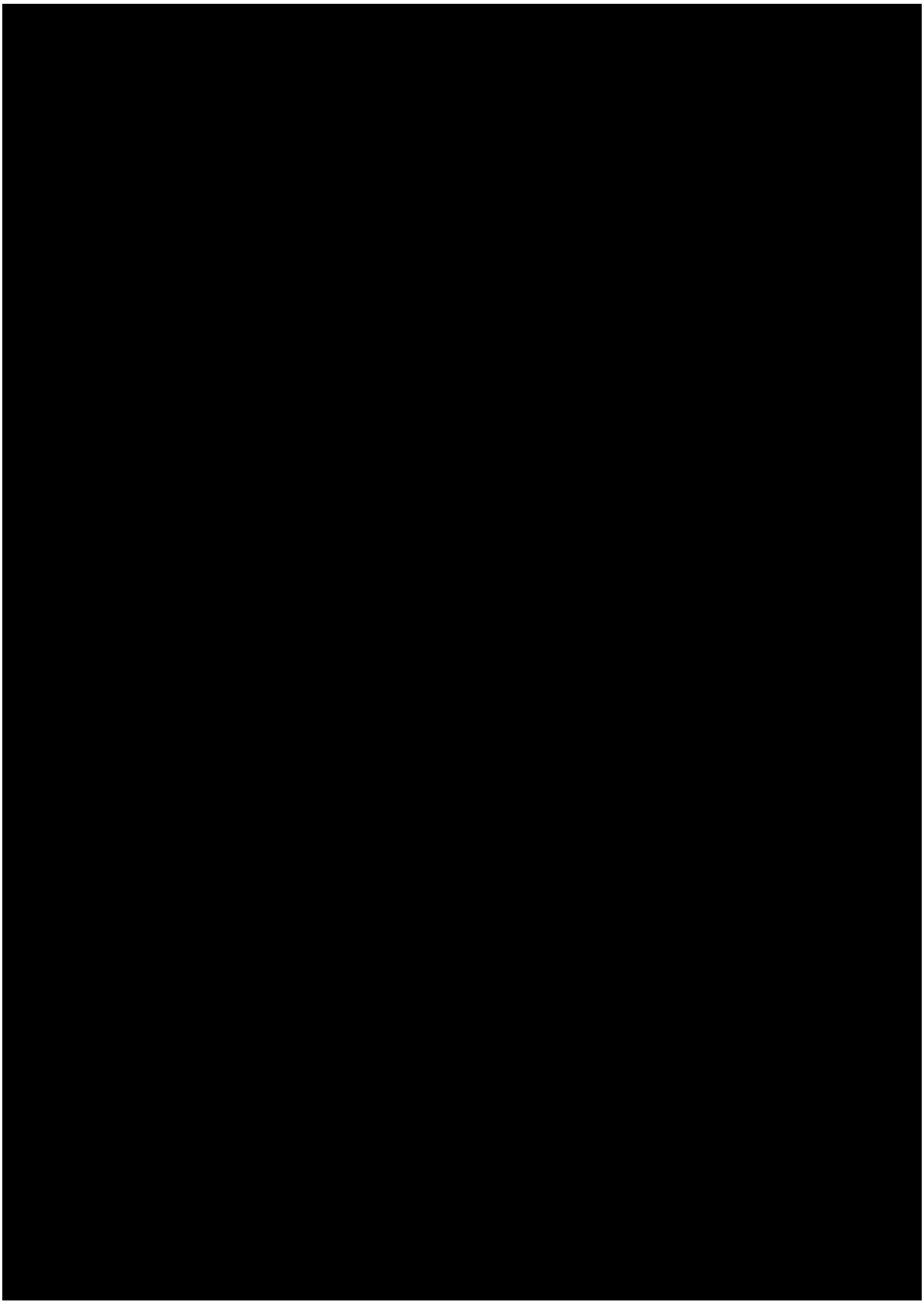

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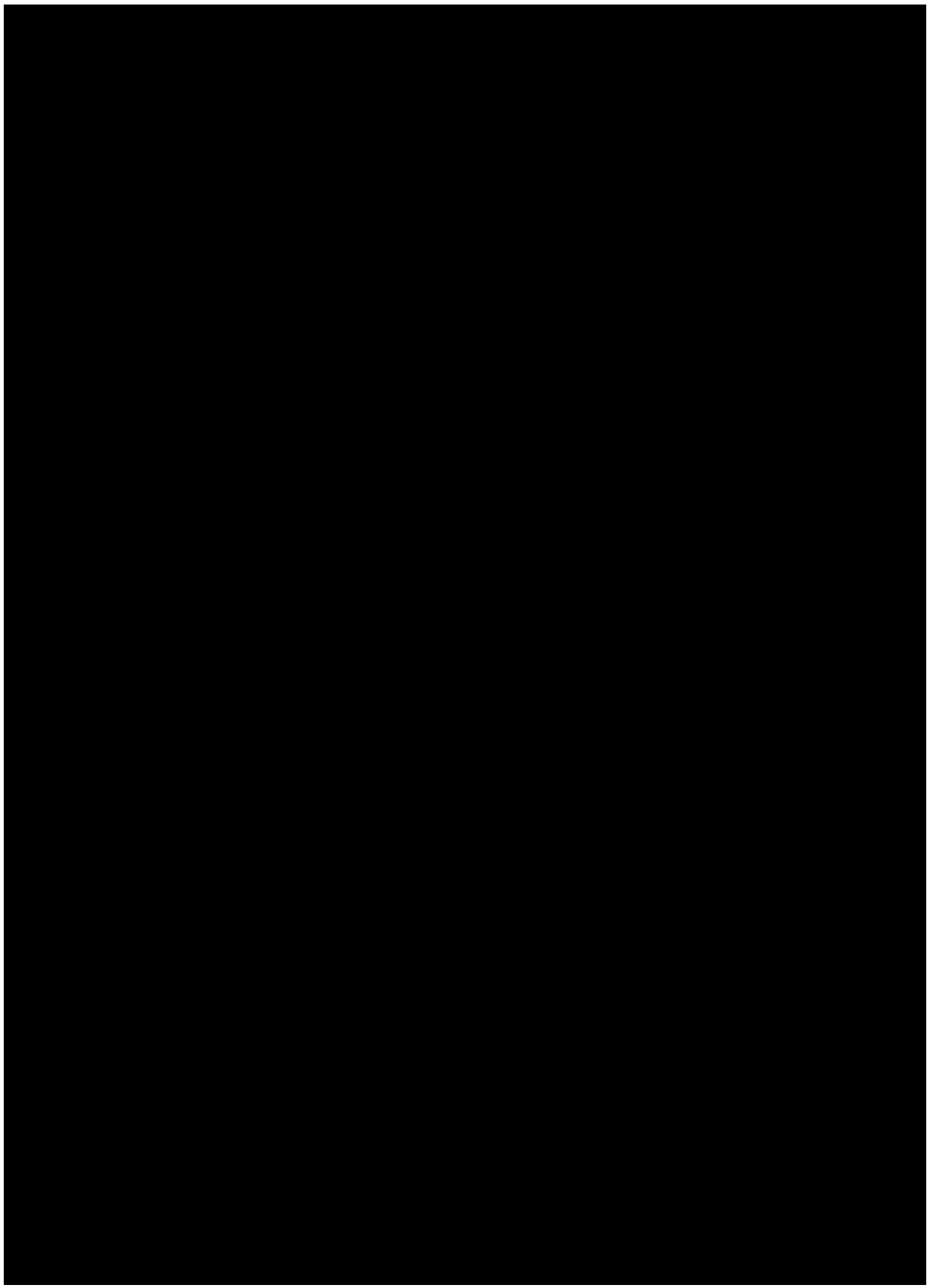

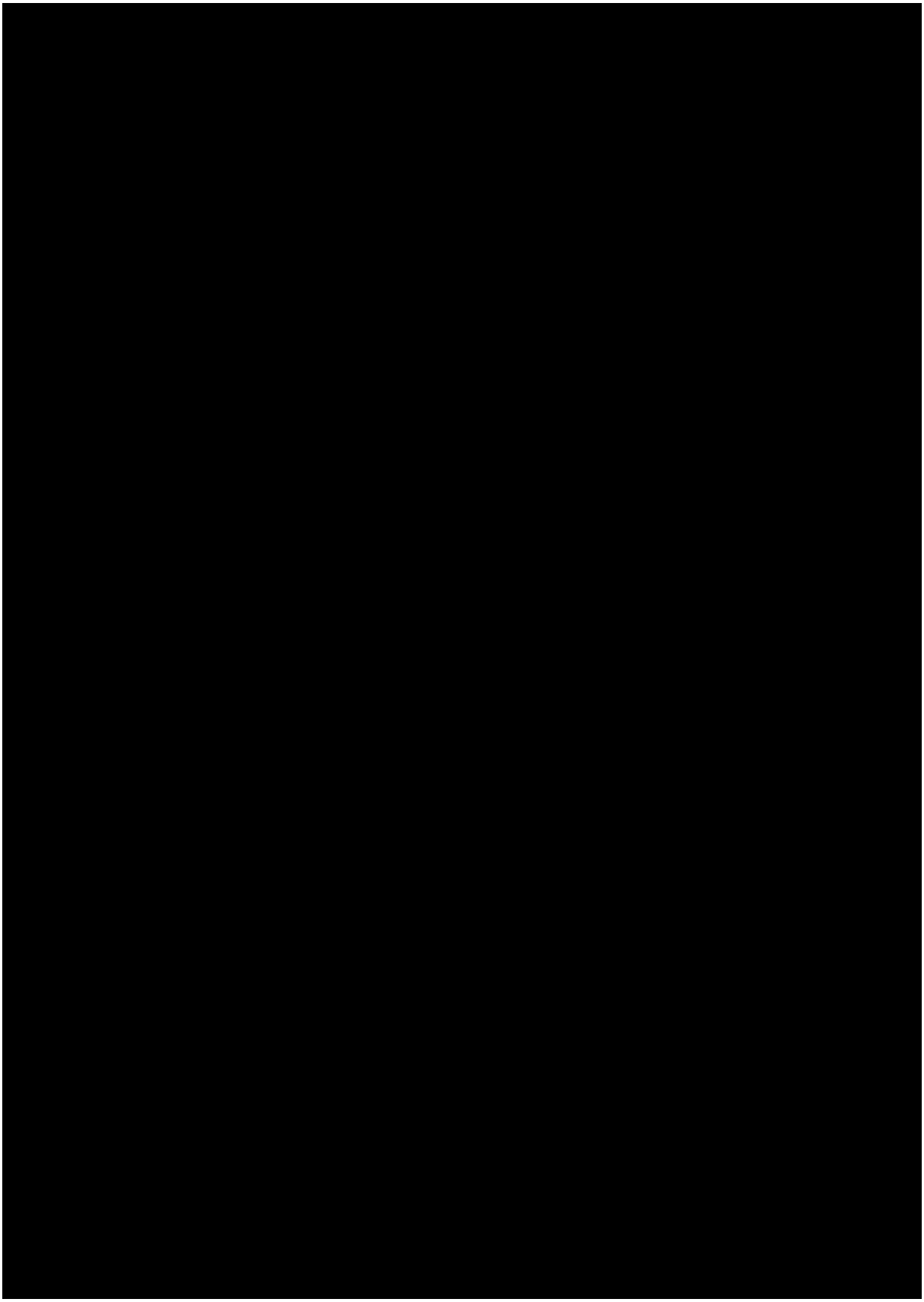

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MR. OSTFELD: I'm at least temporarily done with this exhibit, and it's been about another hour. Would you like to take another break?

THE WITNESS: Yes, please.

MR. OSTFELD: Why don't we take a ten-minute break.

VIDEOGRAPHER: The time is 11:15 a.m. This concludes media unit 2.

(Recess taken.)

VIDEOGRAPHER: The time is 11:29 a.m. This begins media unit 3.

EXAMINATION (Cont'd.)

BY MR. OSTFELD:

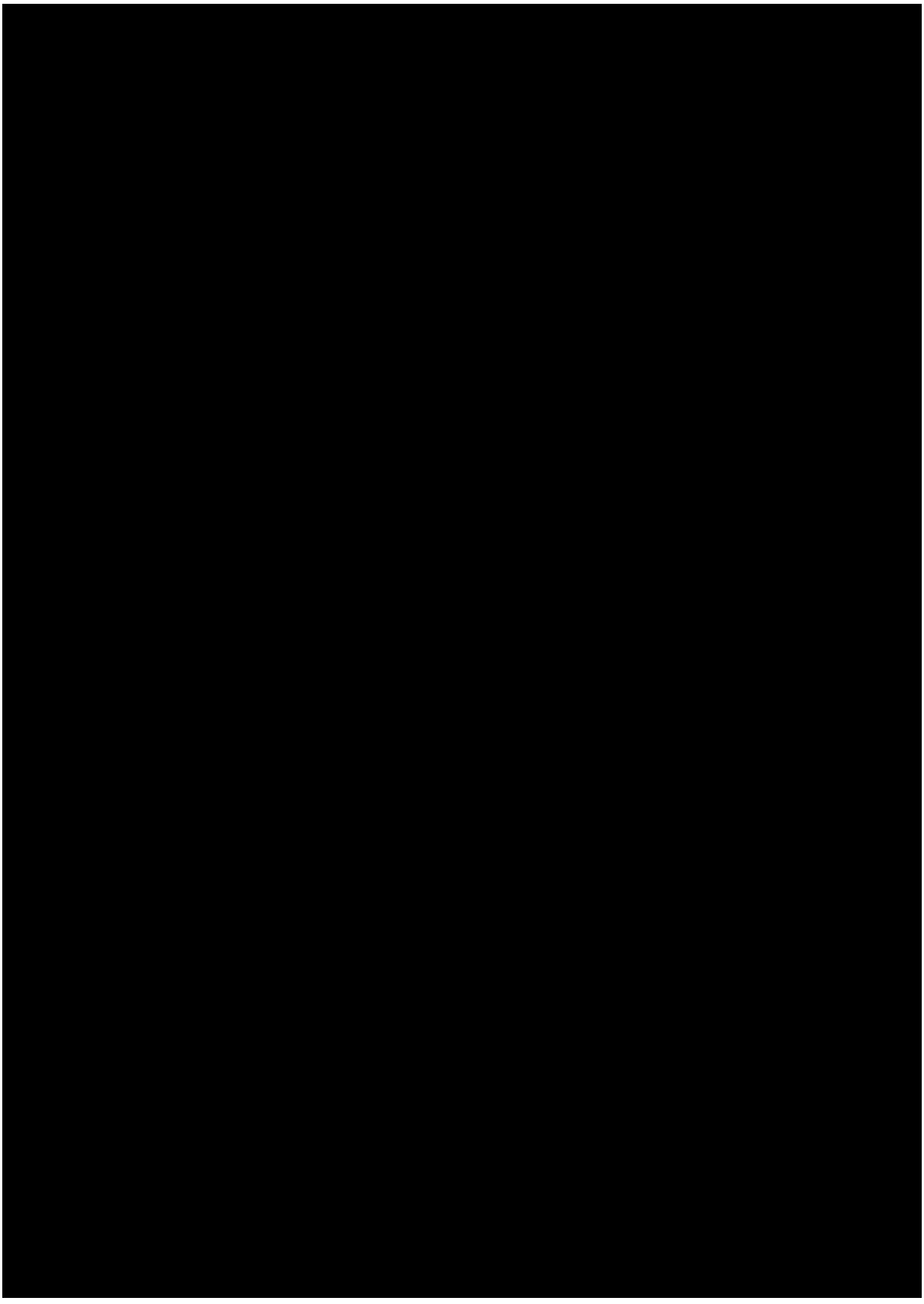
Q. All right. I think what I'd like to do next is get a little better understanding in concrete

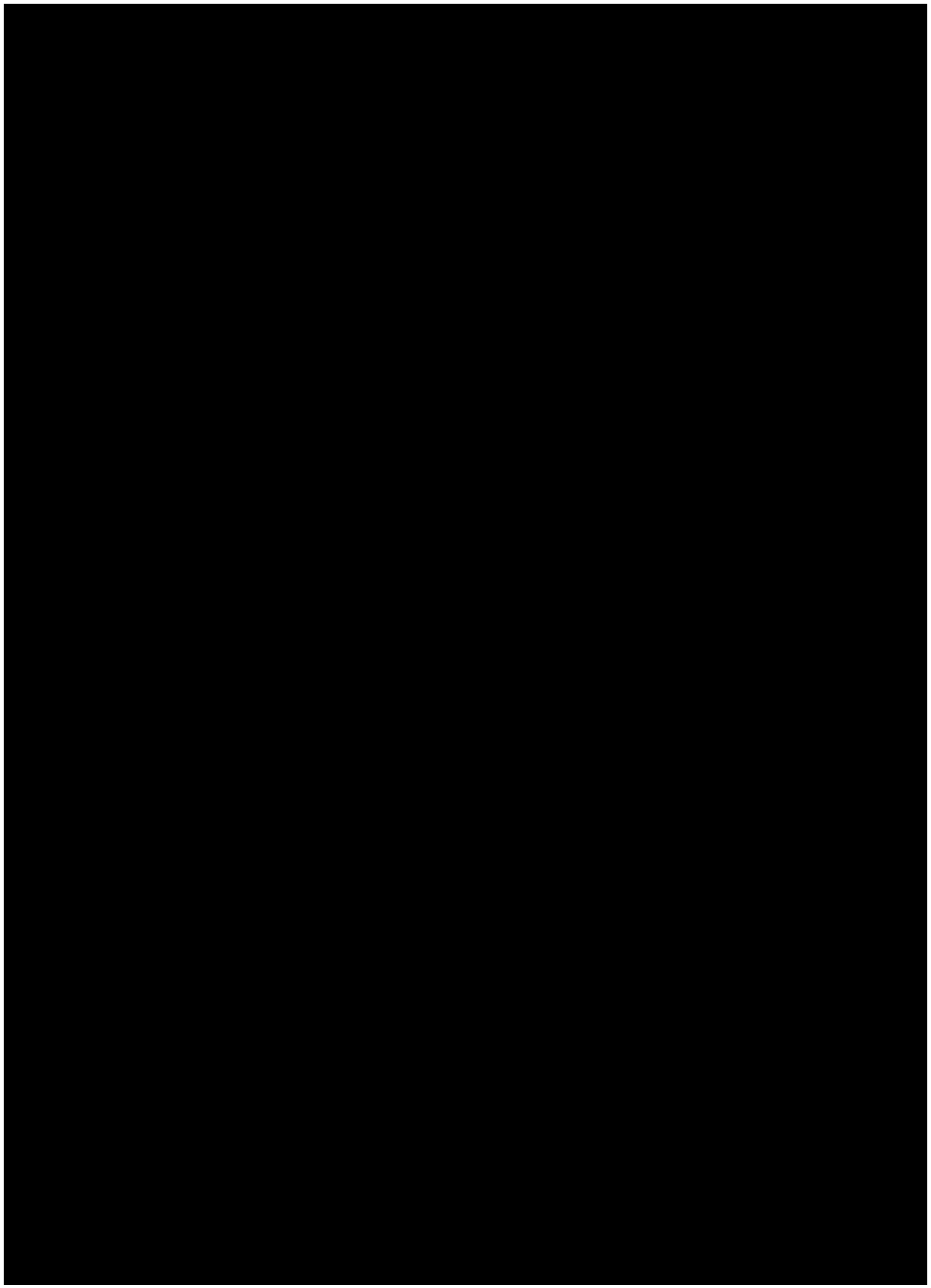
terms what the different tier levels mean in terms of the copays that are paid by the members. So I'm going to share my screen again. And hopefully you now have on your screen what has been marked for identification as -- you know what? I've got to wrong document. Let me switch out.

(A pause in the proceedings.)

Q. Okay. Now I'm going to show you what has in fact been marked for identification as Exhibit 4.

EXH (Mrakovich Exhibit 4, 2015 formulary co-pay schedule effective 1/1/15, three pages, marked for identification, as of this date.)





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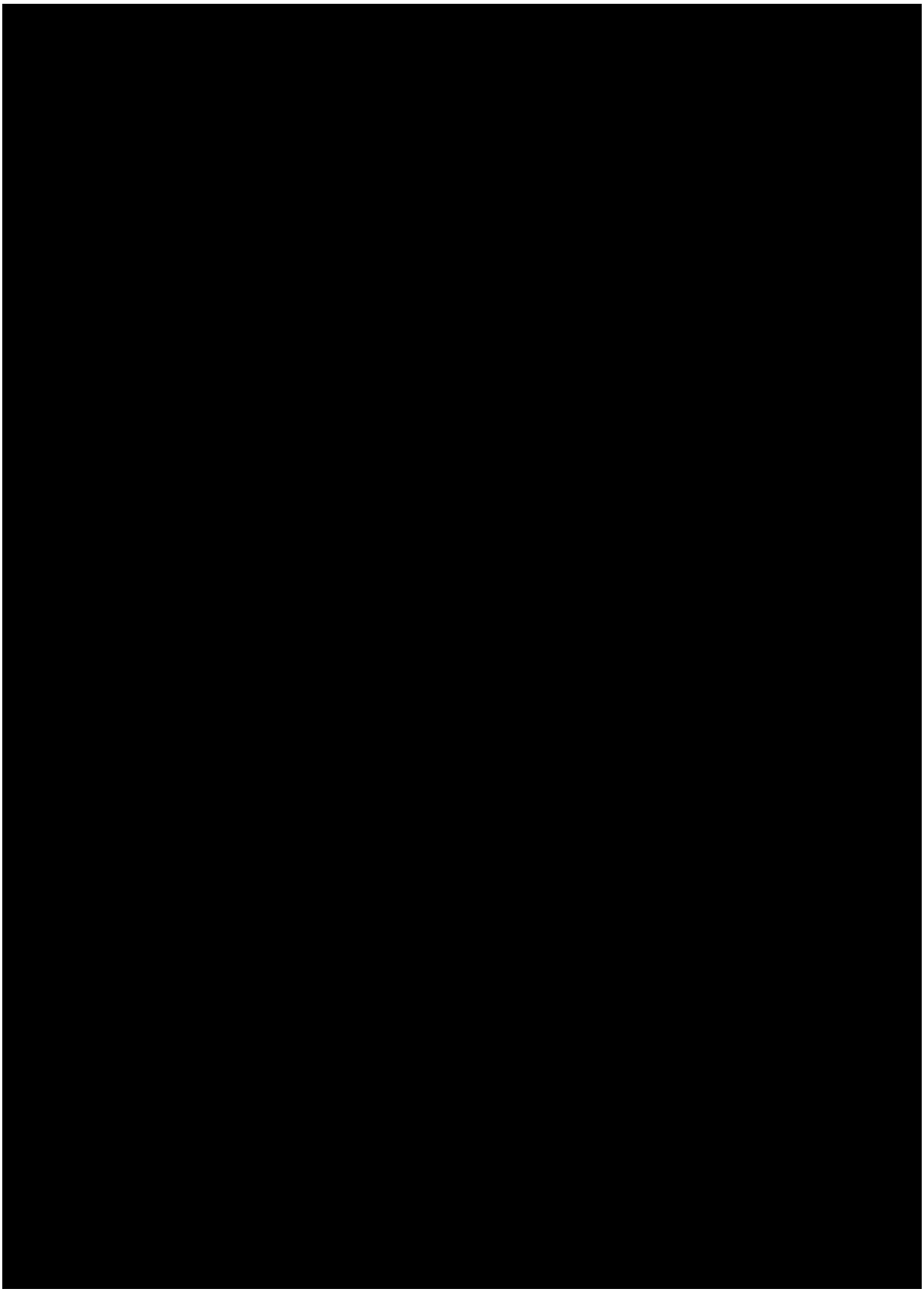


Q. All right. Well, that transitions us nicely into our next exhibit. So one moment.

(A pause in the proceedings.)

Q. Okay, I am now going to show you what has been marked for identification as Exhibit 5.

EXH (Mrakovich Exhibit 5, updated formulary co-pay schedule, effective 8/1/15, three pages, marked for identification, as of this date.)

Q. So this is another version of the 2015 comprehensive formulary. Although it says, "Effective January 1, 2015," on the cover page, on the second page, you'll see there is an effective date of August 1st, 2015. Do you see that?

A. Yes.

Q. And then I'm going to take you to the co-pay chart that we were just looking at. And now in the August 1st, 2015 version of the chart, we have another category, Topaz; is that the plan you were just referring to?

A. Yes.

Q. Okay. Is it unusual for a formulary to be updated midyear?

A. No.

Q. What are the circumstances that would lead to a formulary being updated with an effective

date in midyear?

A. CMS requires a monthly submission of a formulary for Medicare. And --

Q. Okay.

A. -- they may make changes based on the formulary reference file that CMS publishes monthly, the plan reference.

Q. Got it. So it sounds like formularies are routinely updated throughout the year based on what CMS publishes.

A. Correct.

Q. Got it. What about the addition of a new plan middle of the year, is that unusual?

A. That would -- well, that I -- that would be unusual, yes.

Q. Okay.

A. But again, this was the year we were sanctioned, so we couldn't sell Topaz right away beginning in 2015. It was a new plan to us. So we couldn't sell it until we were relieved of the sanction.

Q. Got it. By August 1st, 2015, had the sanction been lifted?

A. Yes.

Q. So -- understood. Let's talk about how

the Topaz plan differs from the other plans. It looks like the Topaz plan has a deductible for brand name drugs, is that right?

A. That is correct.

Q. And then it has zero dollar co-pays for tier 1 drugs like all the other plans?

A. At this point in time, yes.

Q. It looks like its co-pays for some of the other drugs are fairly similar to Ruby other than tier 2 is a little higher, it's closer to Sapphire for tier 2; is that right?

A. Yes.

Q. And actually as I look down the line, it looks like it's identical to Sapphire all the way down the row; is that right?

A. It looks that way.

Q. Okay. Was Topaz designed as a lower-cost alternative plan?

A. Yes, it's a zero-dollar premium plan.

Q. Got it. So to whom is Topaz offered as a zero-dollar premium plan?

A. Medicare members.

Q. Is there an income requirement or an income limit?

A. No.

Q. The other three plans, Ruby, Sapphire and Emerald, those all involve some level of premium?

A. That's correct.

Q. When a drug is removed from a formulary -- we saw earlier for example there were brand name drugs that were taken off the formulary -- when a drug is taken off the formulary, does coverage on that drug halt immediately or is there a transition period?

MR. WHORTON: Objection to form. Vague.

A. That process has somewhat changed over time but generally speaking, the members are always given a notice that that change is going to occur to the formulary so that they have -- it was at least 60 days to work with their physician to choose an alternative or submit a request to choose a new coverage.

Q. Okay. What about when a drug is recalled, does coverage halt on that drug?

A. Yes, if a drug is result, we will pull that for safety reasons from the formulary.

Q. Okay.

A. A drug may still be representative on the formulary because the recall may not impact the entire availability of the drug.

Q. Okay. Got it. So if a drug is recalled in its entirety, then it's pulled from the formulary. If it's not recalled in its entirety, it may stay on the formulary?

A. That's correct.

Q. And is there a transition period when a drug is recalled?

MR. WHORTON: Objection.

A. No.

MR. WHORTON: Vague.

Q. Okay. I'm going to share my screen again.

MR. OSTFELD: For counsel on the line, I will represent that the exhibit I'm about to show is the one that's marked as Exhibit 6 in the Exhibit Share, but I'm going to show it on my Excel screen because Exhibit Share doesn't do real well with native spreadsheets.

EXH (Mrakovich Exhibit 6, formulary Changes Excel spreadsheet 2015-2016 MSP-SUMMACARE-006239.XLSX, marked for identification, as of this date.)

Q. So Ms. Mrakovich, hopefully you have an Excel screen in front of you and you are seeing what I have marked for identification as Exhibit 6, a

spreadsheet?

A. Yes.

Q. Have you seen this spreadsheet before?

A. Probably.

Q. And the reason I'm showing you this is, I want to get a better understanding of the process when a drug is removed from the formulary. So I want to go through some of these columns first and make sure that I understand them.

Column A is labeled, "Scenario," and the most common scenario we see here is formulary in 2015 and NF in 2016. Do you know what that means?

A. Non-formulary, and NF stands for non-formulary.

Q. Okay. So are these drugs or -- the scenario, we were looking at a drug that was on the formulary in 2015, and was pulled from the formulary in 2016?

A. That's correct.

Q. Okay. And then "expected result," it says, "Approved in transition, denied for non-formulary outside transition." Can you explain what that means?

A. Yes.

Q. Okay.

A. So --
Q. Sorry, sorry, go ahead.
A. This process -- this is testing that we do at the beginning of the year for formulary changes. And for year-over-year changes, we do allow member transition. And what that means is, we will allow them a fill within the first 90 days of the plan, we'll pay for a 30-day supply and we'll send a letter to the member and the provider to let them know that we've only covered this as part of transition, and you should work with your prescriber to make sure that you switch to another drug or that you request a prior offer, whatever is needed to continue to take the drug.
Q. Okay, got it. And then "E-to-E comments," first of all, what does "E to E comments" mean?
A. "E-to-E" is end-to-end testing.
Q. Okay.
A. And we're looking to identify if the member is in transition or not in transition.
Q. Okay. Now, I want to understand. You said you tested these at the beginning of the year. Are these real-life member scenarios that you're testing or are these hypothetical scenarios?

A. They are hypothetical but they are in their -- this closely mirrors as close as possible their live environment.

Q. Okay. So you're identifying actual members who may be affected by the formulary change and then you're running a hypothetical scenario of what that would look like for them, is that correct?

A. Yes.

Q. Got it. "HQ code," what is that?

A. That's our headquarter code. That is how we define line of business with MedImpact.

Q. Got it. And SUM03, is that a code for a particular type of plan?

A. SUM03 is for Medicare.

Q. Okay. Then brand name, that seems self-explanatory. It looks like in 2016, for example, Exforge came off of the formulary.

A. Yes.

Q. And Exforge, that's an ACE inhibitor?

A. I'm trying -- I think that was an ACE inhibitor section. Was that -- yeah, I think it was. I don't remember off the top of my head, ACE or ARB, it's one of the two.

Q. Okay. What is "Claim ID"?

A. Claim ID is the came ID and MedImpact

test system.

Q. So is that a claim ID that is assigned to a hypothetical claim or would these correlate to actual claim IDs from, like, the previous year?

A. This would be -- this should be a hypothetical.

Q. Got it.

A. I mean, it's real in their test environment but it's not linked to an actual claim that's processed at a pharmacy in real life.

Q. Okay, got it. Does MedImpact, are these the ones that run the spreadsheet?

A. Yes.

Q. So then there's a status code that is either approved or denied. And from a quick review, it looks like approval or denial is largely tied to the date of the hypothetical. The January 1, 2016 are for the most part approved. The February 1, 2016 are for the most part but not entirely denied.

Can you explain why that is?

A. Did you say February?

Q. I'm sorry, April 1, 2016.

A. Okay. Yes, so again, they are allowed transition fill without an authorization placed for the first 90 days of the plan. So we expect for

those to pay in the first 90 days if it's a drug they had been taking prior to this change. If it's a drug they haven't been taking prior to this change, it would actually deny them in the first 90 days. But if for these members that had been taking it, if -- once you get past the 90 days, it will deny unless they have received a formulary exception.

Q. Okay. And is the 90 days, is that the standard transition period for all drugs that come off the formulary?

A. Yes.

Q. When a drug comes off of the formulary, but you're still in that transition period, from the member's standpoint, does their co-pay change during the transition?

A. No.

Q. In terms of the amount SummaCare pays for the drug that has come off of formulary, is it paying the same amount as it paid the previous year?

A. As it relates to the difference between the member co-pay? I guess I need to correct that, because -- um -- these drugs default to a specific tier if they were not on the formulary. So I'm not sure what tier these were all in 2015. If they were all tier 4, and they were removed from formulary,

then they would still all process in tier 4 in this transition.

If they were in tier 3 in the prior year, and the drug came off, then it would default to tier 4 as a non-formulary drug or brand.

Q. Got it.

A. So their co-pay may change from that perspective year over year.

Q. Okay. So for example, Exforge, which is row 5 here, and Exforge HCT, which is row 6, if we go to column O we've got a co-pay amount, which is 5.13 for Exforge and 9.95 for Exforge HCT. Based on that co-pay amount, are you able to identify which tier each product is in?

A. No, because the problem with their testing system is, I don't know if there's a total drug cost on this somewhere. You cannot count the -- the dollars that they put in these are not relevant.

Q. These are not real dollars?

A. There's no way 15.13 for a thirty-day supply of Exforge is correct.

Q. Fair enough. And when I look over to the right, I see that column Y does have a tier. Would that tell us what tier the drug is in during the transition period, or would that data not be

meaningful for a transition purpose?

A. That would be what it is being paid on this claim at this point in time during transition, so, yeah.

Q. Okay. Understanding the numbers aren't meaningful, I want to get a quick understanding of what the other column headers mean. So column P, D-e-d amount, what is that?

A. Deductible amount.

Q. Okay. Column Q, O-O-P amount?

A. That is the out-of-pocket amount, and it applies to pharmacy only.

Q. Okay. Help me understand what that means as it applies to pharmacy only.

A. So on Medicare, the Part D out-of-pocket is tracked separately than a Part B or medical benefit out-of-pocket.

Q. What is "Applied TDS"?

A. Applied to total drug spend.

Q. Okay. So that identifies how much is applied to the member's total drug spend?

A. Yes.

Q. Okay. What is applied T-R-O-O-P, "Applied troop"?

A. Applies to -- I often have to look these

up, I'll admit to you, Medicare terminology, to keep them all straight. One is the TROOP and one is Total Drug Spend, and they help track them towards their coverage gap level and their catastrophic levels.

Q. Okay, got it. And we'll talk a little bit more about those latter. What about TDT amount and TROOP amount?

A. I don't remember from the testing purposes how those would vary from the applied vs. what they have there.

Q. Okay. Just a few other categories that I was interested in. Price code AD, what is that?

A. That tells you the price, the source of the pricing. If it was AWP or a MAC pricing.

Q. Okay. "Used price," what is that?

A. It -- I'm not certain.

Q. Okay. "Discount PCT," discount percent, and "column aging"?

A. That would be the discount applied to the price code.

Q. And then the ingredient costs?

A. That I'm not certain without doing the math. Should be the calculation of the one times the other. I'm not certain. Again, I don't use these testing scenarios to validate pricing. I use them to

validate formulary administration.

Q. Okay. If the ingredient cost is equal to the co-pay amount, which appears to be the case for Exforge, does that tell you anything meaningful about it?

A. It tells me that the cost of the drugs in this made-up scenario was less than the member's co-pay, so they paid the full price.

Q. Got it. So the last thing that I want to understand before we move off of the formularies topic is what happened with SummaCare's formularies when the Valsartan recall occurred. So I will share screen. And I am showing you what has been marked for identification as Exhibit 7.

EXH (Mrakovich Exhibit 7, side-by-side July October November 2018 formularies.pdf, three pages, marked for identification, as of this date.)

Q. Now, we've done another simplifying exercise here. So this was not a document you're going to have seen before. I will represent to you that what we did was extract from the July, October and November 2018 versions of SummaCare's formularies the entries for Diovan, Irbesartan, Losartan, Valsartan, and several other ARBs for each month. And I'm going to ask you to assume for purposes of

these questions that we have accurately excerpted the formularies.

You can rely on what I put in here and we're at risk if we got it wrong, okay?

A. Okay.

Q. Now, what we did is, we highlighted the changes that we saw across this time period. So for example, you'll note in July 2018, there's no Diovan; and in October of 2018, we highlighted the inclusion of Diovan, and by November 2018, that's no longer highlighted because that's no longer a change. Does that make sense to you?

A. Yes.

Q. Okay. So one change that we noted is the one I just pointed out, that Diovan went from being unlisted in July 2018 to being listed as a tier 4 step therapy drug in October and November 2018. Do you see that?

A. Yes.

Q. Do you know who made this change to the formularies?

A. This is still the Medicare formulary?

Q. Yes.

A. That would have been MedImpact.

Q. Okay. And to your knowledge, was this

change made in response to the Valsartan recall?

A. Yes.

Q. Do you know what alternatives were needed to satisfy the step therapy requirement for Diovan?

A. Not off the top of my head.

Q. Okay. Do you know if they were other ARBs or if they were ACE inhibitors or both?

A. I do not know.

Q. With a step therapy situation, is there usually one specific alternative offered or could there be multiple alternatives and they have to try at least one of those before they can step up to the step-restricted drug?

MR. WHORTON: Object to form, vague.

A. Usually it does list alternatives, multiple alternatives. Rarely, unless it's for a clinical reason, would you only be looking for one. So generally, on a brand, you'd be looking at any of the generics available to treat the same condition.

Q. Okay. And if there were multiple alternatives, do all of the alternatives have to be tried to satisfy the step therapy requirement or is it just one of the alternatives?

A. It depends on the therapy requirement.

Some require one, some require two, and there may be other variations of that.

Q. Okay. Another change that occurred in October 2018, Valsartan oral tablet 160 milligram, 320 milligram, 40 milligram, and 80 milligram, came all into the formulary and the previous generic version stayed on the formulary.

Do you know why the Valsartan oral tablet without HCT was added to the formulary?

A. I do not.

Q. And then it looks like all of the generic versions of Valsartan came off the formulary in November 2018; do you know why that occurred?

A. Not exactly, no.

Q. Okay. And then we have a list of other generic and brand drugs which I think are all ARBs, although it's possible some may be ACE inhibitors, were added in November 2018. Do you know why those were added?

A. I do not.

Q. These changes all would have come from MedImpact?

A. That's correct.

Q. To your knowledge, were all of these changes in response to the Valsartan recall?

A. I do not know.
Q. Okay. Is MedImpact your Pharmacy Benefits Manager for your non-Medicare plans as well?
A. Yes.
Q. Do you know if they made the same changes across the board to their non-Medicare formularies at the same time they were making these changes to the Medicare formulary?
A. We manage custom formularies on the commercial side still.
Q. Got it. Do you have knowledge of what changes you made on the commercial side to your formularies in response for the Valsartan recall?
A. Not off the top of my head. But I can tell you those are more open, especially during that time frame, so we probably were still covering the brand and generics of all the products in some degree on those formularies, so it didn't require same amount of manipulation.
Q. Got it. It was just a matter of switching to other drugs that were already on the formulary.
A. Yes.
Q. Okay. Does SummaCare have one Pharmacy and Therapeutic Committee for all of its plans and

formularies, or does it have separate committees for each formulary?

A. One committee.

Q. The four plan names we looked at earlier, Topaz, Ruby, Sapphire and Emerald, you've already talked about when Topaz came into existence. How long has SummaCare been using the terms Ruby, Sapphire and Emerald for its other Medicare plans?

A. I do not know for sure. That's what it's been since I've been here, but I understand they were different prior.

Q. Okay. Do you know what the terms were before you arrived?

A. I think -- I don't know for certain.

Q. Okay. Aside from the different co-pay amounts and for Topaz, the existence of the deductible requirement, are there other significant differences between the prescription drug benefits across those four plans, Topaz, Ruby, Sapphire and Emerald?

A. No.

Q. In the time that you have been at SummaCare, has it offered any other plans going by names other than Topaz, Ruby, Sapphire and Emerald?

A. Yes.

Q. Okay. What other plans has SummaCare offered?

A. We also offer, but it's part B only, how I say it, it's -- they're called Amber plans.

Q. Okay.

A. And we also added Garnet plans.

Q. Amber and Garnet. Okay. So is Garnet also a Part B only?

A. Garnet is Medicare Advantage, both Part B and Part D.

Q. Okay. So if Amber is Part B only, is there a prescription drug benefit as part of the Amber plan?

A. No.

Q. For Garnet, how does its prescription drug plan differ from the other four plans that we looked at, if at all?

A. I can't tell you off the top of my head. It's just -- it came in at a different premium level and there may be some variations in co-pays. But other than that, all the benefits are the same.

Q. Do you know, is there a deductible with the Garnet --

A. There is not.

Q. -- prescription plans?

A. There is none.
Q. Okay. Earlier we talked about employer-sponsored Medicare Advantage plans that are a relatively small piece of the business. Do those also use the terms Topaz, Ruby, Sapphire, Emerald, Garnet, to describe those plans?
A. Not -- no.
Q. To your knowledge, do any of the employer-sponsored Medicare Advantage plans have a deductible for prescription drugs?
A. No.
Q. Do the co-pays for the employer-sponsored Medicare Advantage plan differ from plan to plan or is there a kind of a universal co-pay structure for the employer plans?
A. Some of the employer plans near our -- some of our individual plans, and others have made up their own co-pay structure.
Q. So the co-pay structure is negotiated separately for each employer-sponsored Medicare Advantage plan?
A. Yes.
Q. Other than the Topaz plan, are you aware of any other SummaCare Medicare plan that has a deductible for prescription drugs?

A. That is the only one.
Q. Do any of the Medicare plans have a coinsurance structure rather than a co-pay structure for prescription drug benefits?
A. None of the individual ones have coinsurance.
Q. Do you know if any of the employer ones do?
A. Off the top of my head, I don't recall if there are or not.
Q. Okay. On the commercial plan side, does SummaCare have deductibles for prescription drug benefits for some of its commercial plans?
A. Yes.
Q. And does the co-pay structure differ from plan to plan on the commercial side or are there uniform co-pay structures?
A. There are differences.
Q. Do you have a sense of what the range of premiums are across the Medicare plans today?
A. I have a sense, yes.
Q. You've said that the Topaz plan is a zero plan. So on the low end of the range it's zero. What's the high end of the range of premium for a SummaCare Medicare plan?

A. I know Emerald is our most expensive plan, and that's upper one hundreds, low two hundreds. I don't remember where that ended up.

Q. When you say upper 100s, low 200s, that's the monthly premium in that?

A. Yes.

Q. Okay. Is the concept of out-of-pocket maximum, is that something that applies to Medicare plans at all?

A. On the Part B medical benefits side, yes. Not on Part D side.

(A pause in the proceedings.)

THE WITNESS: I know. I don't know why CMS did that, right? It's on the part B as in Boy, medical benefits. The maximum amount would apply.

Q. In the time you have been at SummaCare, have any of the Medicare plans had a formulary that differs from the comprehensive formulary provided by MedImpact?

A. Could you say that again?

Q. Sure, I can probably simplify it. In the time that you've been at SummaCare, have all of the Medicare plans been on the same formulary?

A. Yes.

Q. And that formulary is the one that

SummaCare selects from the options provided by MedImpact?

A. Yes.

Q. In terms of the total cost of a prescription drug reimbursed under a Medicare plan, is that -- and I'm talking about the combined cost by both the member and SummaCare -- is that cost the same regardless of which plan is used?

A. I would say yes.

Q. The breakdown of the cost can vary depending on which plan, because the co-pay amount varies, is that fair?

A. Yes.

Q. So under a higher-cost plan, the member pays a lower co-pay, and SummaCare picks up more of the cost, and vice-versa for a lower-cost plan?

A. Generally speaking.

Q. Okay. But for tier 1, zero dollar co-pay for all of the plans.

A. Except for what we looked at there. There were some plans that had two dollars.

Q. Okay, right. Does SummaCare support mail order pharmacy benefits through its plans?

A. Yes.

Q. Are there incentives for mail order

pharmacies?

A. I guess it may be important to note that mail order and 90-day retail are the same, so we're not incentivizing mail order over retail. That changed over time. It used to be you could get a 90-day supply of tier 2 and tier 3 drugs at a better rate at mail than retail 90, but we've since made it such that it's the same no matter where.

Q. Okay. We've kind of talked around a little bit the difference in coverage phases for Medicare prescription drug coverage, and I'd like to spend a little bit of time going through those phases and getting a better understanding of what they are and how they impact the coverage under the different plans, okay?

So as I understand it, there are different phases of Medicare prescription drug coverage and the amounts paid by the member and potentially by the plan differ, depending on which phase of coverage you're in, is that a fair characterization?

A. Yes.

Q. Okay. And as I understand it, the first phase is generally referred to as the annual deductible phase, is that right?

A. That's correct.

Q. All right. And as I understand it, that phase is applicable to the extent that there is a deductible and, during that phase, the member pays the cost until the deductible is satisfied; is that correct?

A. At a specific tier level as specified, yes.

Q. Okay. So for most of SummaCare's Medicare plans, there is no annual deductible phase because for most of your plans, there is not a deductible applicable to prescription drugs, right?

A. Correct.

Q. Okay. And the one exception would be Topaz, which does have a deductible for brand drugs, is that right?

A. Tier 3 and 4 drugs.

Q. Okay, tier 3 and 4, fair. So the Topaz member has an annual deductible phase for tier 3 and 4 drugs until they have satisfied their deductible?

A. That's correct.

Q. Okay. And in that phase, for those plan members, SummaCare doesn't pay the costs of the prescription drugs until the deductible is satisfied?

A. That's correct.

Q. So then the next phase, as I understand it, usually referred to as the initial coverage period, is that how you've heard it referred?

A. Yes.

Q. And in that phase the, as I understand it, the patient is responsible for the co-pay if there is a co-pay, and then SummaCare picks up the remaining cost of the prescription drug, is that right?

A. Yes.

Q. And I think as you mentioned earlier, that's similar to how it works with a commercial fully-insured plan. SummaCare is basically picking up the rest of the tab after the co-pay; is that right?

A. Yes.

Q. Okay. Is there a fixed dollar amount or a fixed range after which the initial coverage period ends?

A. Yes.

Q. And has that not changed over time?

A. It changes every year. That's established by Medicare.

Q. Okay. Do you know what the current number is?

A. It's in the four-thousand-some range.
Q. And are you able to approximate how much that number changes each year, either on a number or a percentage basis?
A. Generally less than a hundred dollars. But it could be over a hundred. I don't -- you know, it's -- it does change each year. Not by thousands, but hundred or couple of hundred maybe.
Q. Okay. And that's specifically the number for prescription drug coverage. Once you've exceeded that number for prescription drug coverage, you move into the next phase?
A. Yes.
Q. So when a member has filled more than approximately four thousand dollars' worth of prescription drugs in a given year, they move out of the initial coverage period, is that right?
A. Correct.
Q. And then as I understand it, the next phase is known as the coverage gap phase or sometimes the donut hole phase, is that right?
A. Yes.
Q. For this one, I think I'd like you to just explain to me what happens to the prescription drug coverage in the coverage gap phase.

A. Well, and that changed significantly over this whole time frame we're referring to as well.

But in the coverage gap phase, what happens is, the member goes to a coinsurance, which has changed over the years. They would pay, for a generic drug, they would pay 25 percent of the cost of the generic drug and SummaCare would pay the rest. And for a brand drug, the member would pay 25 percent of the cost of the drug, SummaCare would pay five percent, that's how it's broken down, and then the manufacturer pays 70 percent for brand name drugs.

So for generic drugs, member pays a percentage and SummaCare pays the balance.

Q. Okay. So instead of the co-pay structure, that goes away and then now we're in a coinsurance structure.

A. Correct.

Q. And you say today, the coinsurance structure is 25 percent member, 75 percent insurer?

A. Yes.

Q. You say that's changed over time. Can you explain how it's changed?

A. That percentage has changed as Medicare has worked to, what they call close the gap. It used

to be a higher member percentage and each year they've ratcheted it down. The last couple of years have been consistent with 25.

Q. Okay. So, you know, here we're going all the way back to 2012. Do you know approximately what the percentage was on the member side in 2012?

A. I do not recall.

Q. Putting aside specific years when the member percentage was higher, do you know approximately what the highest member percentage was before Medicare started closing the gap?

A. I can't, to be honest, I can't even remember how high it ended up going.

Q. Okay. How about in the time you've been with SummaCare, how much has the coinsurance changed in the gap coverage in the time you've been with SummaCare?

A. I remember it being at 35 percent at one point, and it may have been even higher than that before that.

Q. Okay. And then it's just sort of stepped down each year over time?

A. Not -- yeah, until a point they considered the gap closed now, so it's not looking to adjust as far as I know from here.

Q. Okay. When we were looking at the formularies earlier in the restrictions and requirements codes, there was a GC code, a gap coverage code. What happened for drugs that have the GC designation during the coverage gap period?

A. Well, for drugs with a GC, that means that we will cover them at that initial coverage phase level through the gap phase.

Q. Okay. So for a GC drug, the member continues to just pay their normal co-pay for that drug.

A. That's correct.

Q. Okay. They don't move into the coverage gap mode of coinsurance?

A. They do for drugs and they do from their benefit perspective, but for that particular drug and claim, it will just take the co-pay.

Q. Got it. Is there a fixed dollar amount or dollar level at which the coverage gap period ends and you move into the next phase of coverage?

A. Yes.

Q. Do you know approximately what that level is now?

A. It's in the seven -- low $7,000 range.

Q. Okay. And has that number changed over

time?

A. Yes.

Q. Are you able to approximate about how much that number changes each year?

A. Not exactly. Probably close to similar ratios, but I can't say for sure.

Q. In your experience, has it tended to move up at approximately the same percentage each year as the level that initiates the coverage gap period?

A. Yes, I would -- I would say.

Q. Okay. Do you know if they are tied to the same benchmark or the same index?

A. I have no idea.

Q. You don't know what index or benchmark is used to adjust those numbers each year?

A. I do not.

Q. Okay.

A. Probably in the hundred-page CMS call letter summary.

Q. Fair enough. Do tiers matter during the coverage gap period?

MR. WHORTON: Objection to form.

A. Only from the standpoint that the coverage gap level coverage is defined in five tiers.

Q. Okay. I see. So you mentioned earlier that it differs for a brand drug vs. the generic drug. So tier placement impacts how the coinsurance works in the coverage gap period?

A. Well, that's based on a brand or a generic drug. But we apply -- when you submit to CMS, you say we define it at a tier level, this is the tier we'll cover through the gap discount. We're not fussing what drug we cover. We're just fussing at a tier level. We thought -- we selected a tier level what drugs will have coverage through the gap, so we applied coverage gap to tier 1.

Q. Okay. I see. Let me make sure that I understand. So we talked earlier about the drugs that have the GC code. Do you apply the GC code to all drugs in a particular tier?

A. Yes.

Q. Got it. So all tier 1 drugs are also GC drugs.

A. Yes.

Q. Got it. Do you know approximately what percentage of SummaCare members in the Medicare plans reach the coverage gap phase each year?

A. I don't have that number off the top of my head.

Q. Okay. Are you able to approximate a range of what percentage of SummaCare members reach the coverage gap phase each year?

A. I don't feel comfortable doing that off the top of my head. I have resources for that, but I didn't look at these numbers recently.

Q. Is that something that is contained in SummaCare's public reporting to CMS?

A. I'm not sure.

Q. If you were trying to find the number of what percentage of SummaCare members reached the coverage gap phase each year, is there a particular report or document that you would go to to find that information?

A. Yes.

Q. What report or document would you go to?

A. I could run some reports out of the MedImpact system and there probably, our financing tracks that as well.

Q. Got it. Okay, so that takes us to the fourth, and as far as I know the final phase, which is generally referred to as catastrophic coverage, is that right?

A. Yes.

Q. And that's triggered above that

threshold you mentioned before, the seven thousand or so dollars, is that right?

A. Yes.

Q. Okay. So during the catastrophic coverage phase, what happened to the prescription drug benefit, how does it change?

A. It goes to a five percent -- it's the greater of five percent for a dollar amount established for generics, and a dollar amount established for brands.

Q. Okay. So the members' share go down when they enter the catastrophic coverage phase?

A. Yes.

Q. And then in terms of the costs, the remainder of the costs and who picks those up, does that differ for generic and brand drugs?

A. I believe that all goes to the plan. I don't -- I'm not recalling if the manufacturer pays anything in the catastrophic phase.

Q. Okay. So -- okay. So five percent or so is to the member and then the remainder to the plan?

A. Yes.

Q. Does the plan, does SummaCare get any additional money from the government from CMS to

cover members that enter the catastrophic coverage phase, or is it the same amount regardless?

A. As part of the bid process, you estimate what you believe will go -- how many members you believe will go into catastrophic, so they build that into that monthly payment, expecting you to get to a certain level of catastrophic membership.

Q. So that number is baked into the monthly payment?

A. Yes.

Q. Can those monthly payments change during a bid period based on if you have, for example, a lot more customers, a lot more members who go into catastrophic coverage, can you get an adjustment from Medicare for that?

A. My understanding is that they -- you get the same monthly payment throughout the year based on your bid and that would be trued up later.

Q. So there's a true-up process to deal with that?

A. And I'm using the term "true-up." I don't know the official term. But yes.

Q. So if -- for the Medicare plans, if costs dramatically exceed the bid assumptions due to circumstances beyond SummaCare's control, there's a

way to true up those payments and get more money from CMS?

A. I do believe so.

Q. Are you able to approximate what percentage of SummaCare members reach the catastrophic coverage phase each year?

A. No, that's -- with the gap, I don't recall.

Q. If you wanted to get that information, would you go to the same MedImpact reports you referenced earlier or would there be a different report you would go to for that?

A. I'd have to look for sure. I'm not sure if it's all captured on one or if it would be two different reports.

Q. Okay. Do you know what the names of those reports are? Is there a reference you use to describe those reports?

A. No, I don't know the name. I just look through the whole list of reports they have available.

Q. Got it. Is it your understanding that a low-income Medicare enrollee can receive extra help from the government?

A. Yes.

Q. To help pay for plan premiums, deductibles and co-pays?

A. Yes.

Q. How does that work?

A. The member would have to submit to CMS, or maybe through Social Security, their income level and they can fall into four different categories where they may have to pay zero dollars for their premium, deductibles and co-pay, or they maybe go into a different level where they have an established lower co-pay for generics and a separate established co-pay for brands.

And then there's the highest level. The least amount of help gives them 15 percent coinsurance for the plan benefit, if that's better, around 15 percent for the plan benefits.

Q. And is there a formal application process for that extra help?

A. Yes. That would be my understanding.

Q. Okay. Is the application made through SummaCare or is it made directly with the government?

A. I believe it's made with the government. We do not make that determination.

Q. Does SummaCare or its Pharmacy Benefits Manager play any role in administering the extra help

when it's given?

A. When it's approved, then our eligibility system is updated and we cede that over to MedImpact so they know how to adjudicate the claim.

Q. So it impacts other claims that are adjudicated by MedImpact?

A. Yes.

Q. Does it impact the costs that are paid by SummaCare for a given prescription?

A. Only from a standpoint that if the member is paying less, we pay the differential.

Q. Got it. So the extra help doesn't mean the government gives SummaCare a little extra money to pay for those drugs, it's just they tell you you're operating under a different co-pay structure for those members?

A. I know the bid as a -- accounts for catastrophic also accounts for what your expected LICS coverage is, so Low Income Subsidy.

Q. And was that L-I-T or L-I-S?

A. L-I-C, and then S. Yes, I've seen it changed.

Q. Okay. Does SummaCare require members to use network pharmacies, to use their prescription drug benefit under the Medicare plans?

A. Yes, they should go to the network pharmacy.
Q. Okay. And who determines the network pharmacies?
A. We use the MedImpact network.
Q. Do you have any insights or transparency into how MedImpact selects pharmacies for its network?
A. I don't think so.
Q. To your knowledge, do the network pharmacies vary from year to year?
A. Slightly.
Q. Does SummaCare provide any coverage for prescriptions that are filled outside of the network?
A. Yes.
Q. Okay. And how does that work?
A. They would submit a direct member reimbursement and then they would be reimbursed the difference -- they would be reimbursed based on what our contracted rate at a network pharmacy would be.
Q. I see.
A. That's their co-pay.
Q. So if a member fills at an out-of-network pharmacy, they basically pay for the prescription and then they get a reimbursement that

would be equivalent to what you would have paid to a network pharmacy.

A. Yes.

Q. Got it. And in that sense, the member is responsible for the difference between that and the cost of their prescription?

A. Yes.

Q. Okay.

MR. OSTFELD: I'm about to enter into a new phase of the deposition. The exhibit that I'm going to load is a big one, it's going to take a long time to load. And it's also 12:37 on your end.

So it seems like it might be a good time for our lunch break but if anybody wants to take a shorter break and then come back and go for a while before lunch, I'm fine with that as well.

VIDEOGRAPHER: The time is 12:38 p.m. This concludes media 3.

(Luncheon recess: 12:38 p.m.)

AFTERNOON SESSION

(1:32 p.m.)

TIFFANIE MRAKOVICH, having been previously sworn, resumed the stand and testified further as follows:

VIDEOGRAPHER: The time is 1:32 p.m. This begins media unit 4.

MR. OSTFELD: All right, before I resume my questions, I had a call with Mr. Whorton while we were on our break, and I understand that the witness has a scheduling conflict at 3 o'clock Eastern Time. So he offered tomorrow to finish the deposition. Unfortunately, I have basically no holes in my calendar tomorrow.

So what we've agreed to do is get as far as we can in the next hour-and-a-half, and then we'll just find a time that works for folks and finish up whatever we're not able to do today on a later date.

Charlie, does that accurately reflect what we discussed?

MR. WHORTON: It does, thanks, Greg.

MR. OSTFELD: Okay.

EXAMINATION (Cont'd.)

BY MR. OSTFELD:

Q. All right, so Ms. Mrakovich, in your

role at SummaCare, are you involved in negotiation of SummaCare's agreements with its Pharmacy Benefits Manager?

A. Yes.

Q. Has that been true for as long as you've been the Director of Pharmacy?

A. Yes.

Q. Okay. What is your role in that process?

A. We actually hire a third-party vendor to assist us in reviewing the contracts and, you know, if we go to RFP, evaluating all the vendors and having a feel for where the market's going to make sure that we get a fair price in the market.

Q. Okay. So, and I apologize, it may be on my end, but your voice sounds a little softer to me than it did before the break. I don't know if you're further from the phone but if there's anything we can do on your end?

A. Is that any better?

Q. I think that's a little better, yeah.

A. Okay.

Q. Okay. So I am going to share screen and I will show you what has been marked for identification as Exhibit 8.

For the record, this is a document entitled, "Service Agreement between SummaCare, Inc., and MedImpact Healthcare Systems, Inc." I believe this one is from October 2011, with 2016 through 2018 amendments.

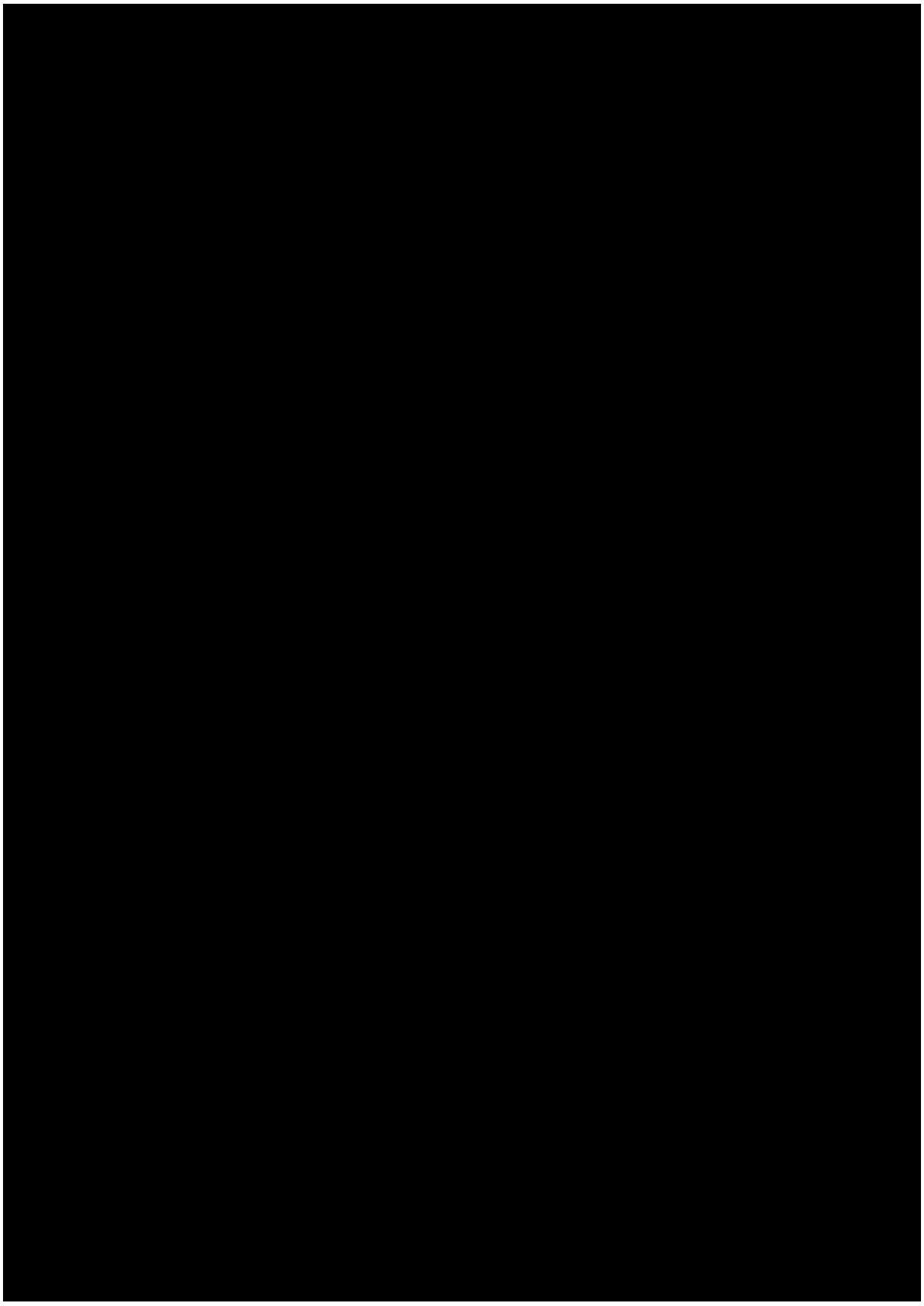
EXH (Mrakovich Exhibit 8, PBM Agreement with MedImpact, 225 pages, Bates numbered MSP-SUMMACARE-005978 through 006202, marked for identification, as of this date.)

[redacted]

[redacted]

[redacted]

[redacted]



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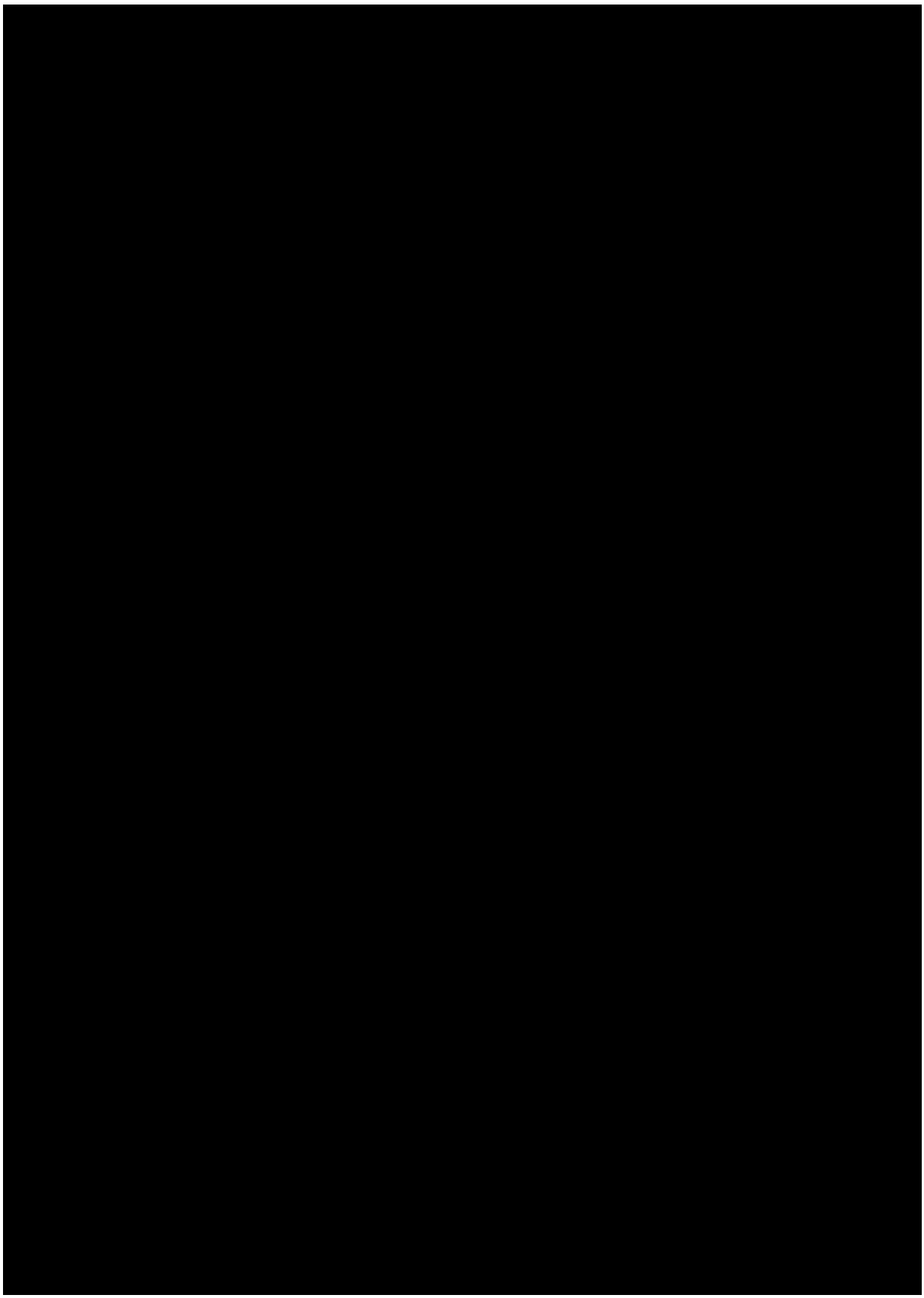

[redacted]

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[redacted]

Q. I'd like to next show you what has been marked for identification as Exhibit 9.

EXH (Mrakovich Exhibit 9, e-mail chain Bates numbered MSP-SUMMACARE-2670 through 2672, marked for identification, as of this date.)

[redacted]

[redacted]

[redacted]

[redacted]

Q. I am going to show you what has been marked for identification as Exhibit 10. It bears Bates numbers MSP-SUMMACARE-2358 through 2359.

EXH (Mrakovich Exhibit 10, MedImpact recall letter 7/18/18, Bates numbered MSP-SUMMACARE-002358 and 2359, marked for identification, as of this date.)

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Q. All right. I'm now going to show you what's been marked for identification as Exhibit 11.

EXH (Mrakovich Exhibit 11, MedImpact member letter dated 7/18/18, with cover e-mail, Bates

numbered MSP-SUMMACARE-003035 through 3041, marked for identification, as of this date.)

[redacted]

[redacted]

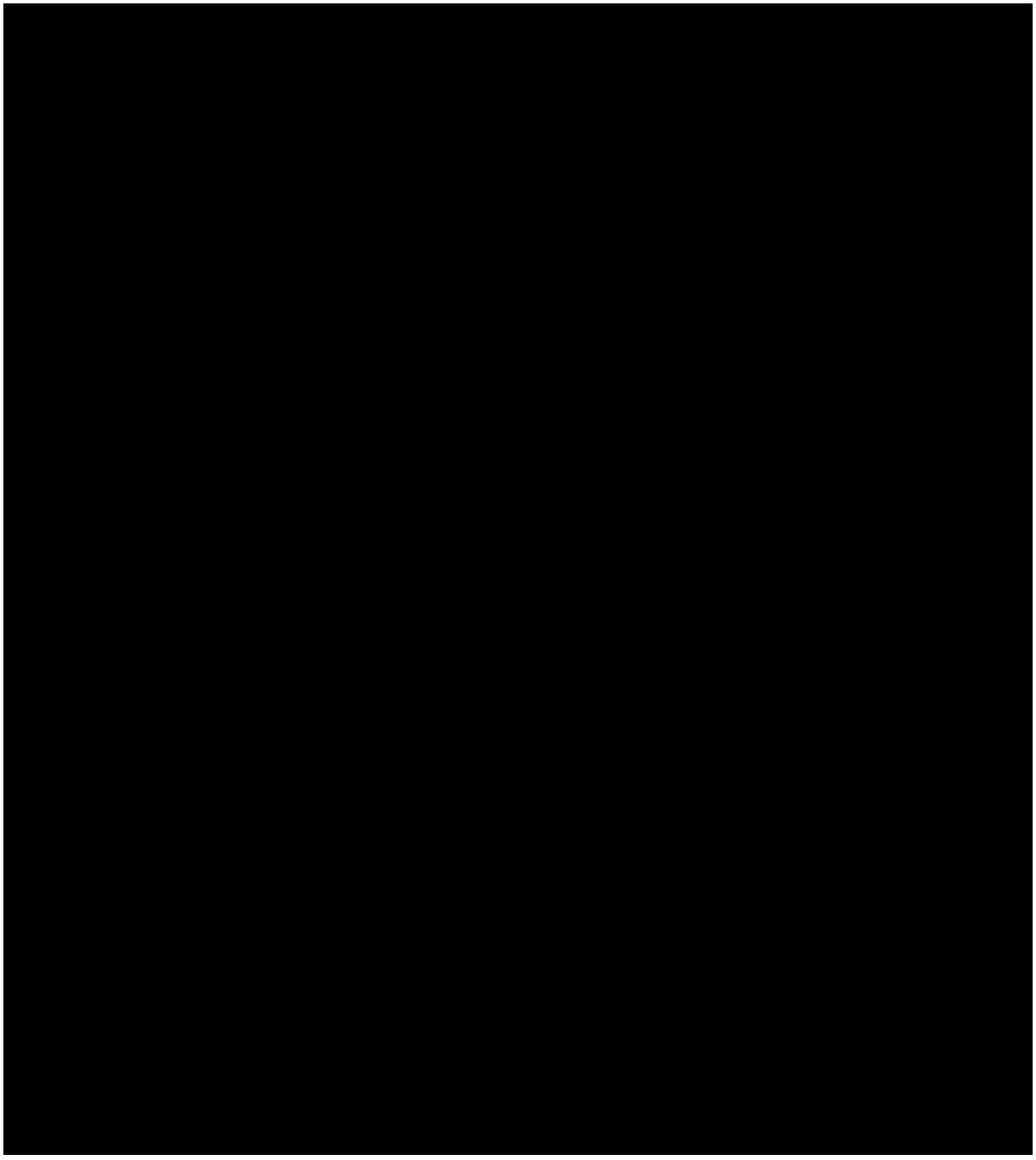
[redacted]

[redacted]

MR. OSTFELD: Sorry, this next one is taking a moment to load.

(A pause in the proceedings.)

EXH (Mrakovich Exhibit 12, MedImpact Camber recall letter with cover e-mail chain, Bates numbered MSP-SUMMACARE-002836 through 2839, marked for identification, as of this date.)



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Q. I'm now showing you what has been marked for identification as Exhibit 13.

EXH (Mrakovich Exhibit 13, MedImpact Torrent recall letter with cover e-mail chain, Bates numbered MSP-SUMMACARE-2823 through 2826, marked for identification, as of this date.)

[redacted]

[redacted]

[redacted]

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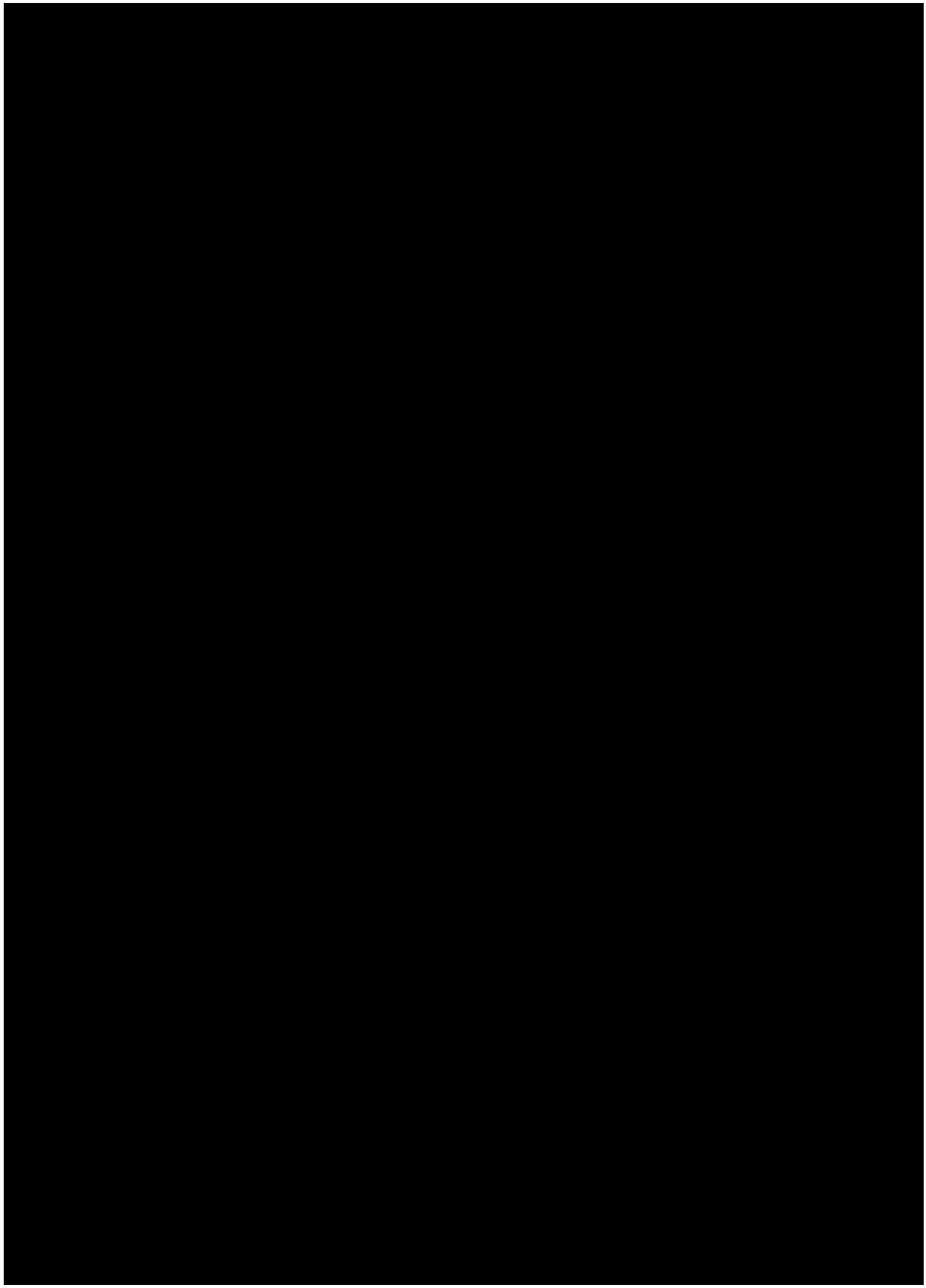
[redacted]

MR. OSTFELD: Given time constraints, I'm going to skip ahead to what's been marked for identification as Exhibit 15. This is an e-mail bearing Bates numbers MSP-SUMMACARE-3032 through

[redacted]

[redacted]



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(Continued on following page.)

MR. OSTFELD: I'm at a decent stopping point and I know that we're about two minutes away from what I know is your stopping point. Do we want to stop here for the day?

THE WITNESS: I'm good with that.

MR. OSTFELD: Okay. Charlie and I will circle off and we'll schedule the next session.

MR. WHORTON: Sounds good.

VIDEOGRAPHER: The time is 2:58 p.m. Here ends this session of the deposition of Tiffanie Mrakovich.

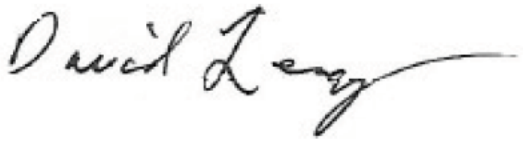
(Time noted: 2:58 p.m.)

C E R T I F I C A T E.

I, DAVID LEVY, a certified court reporter and notary public of the State of New Jersey, certify that the foregoing is a true and accurate transcript of the stenographic notes of the deposition of said witness who was first duly sworn by me, on the date and place as hereinbefore set forth.

I FURTHER CERTIFY that I am neither attorney, nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel in this place, nor am I financially interested in this case.

IN WITNESS WHEREOF, I have hereunto set my hand this 6th day of August 2021.



DAVID LEVY, RPR, CRR

LICENSE NO. 30X100234000

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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